Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend Item 23a per Dr., G863, Old 23/07dbb of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JANUARY 9<sup>™</sup> 2007 **Physician** STEINBACH 8:45 P BETTYE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RUXTON PIKESVILLE NURSING HOME PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1072171911 1 □ M 2 🔽 F 95 MD 214-01-8153 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show 1 ☐ Yes 2 💢 No BALTIMORE BALTIMORE Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 USA 7 SUDBROOK LANE Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. δ 3 Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) **AGENT** REAL ESTATE permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If Item 27 Is marked other any Injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WARSHAFSKY **OSEROFF** LENA NATHAN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 FAIRWAY DRIVE - TOWSON, MD 21286 CHARLES OSEROFF / NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ANSHE EMUNAH(AITZ CHAIM) 1/12/2007 HALETHORPE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature Funeral Service SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respirator disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed Atherosclerotic Heart Disease and burial-trai Due to (or as a consequence of) オズろみ Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9☐Unknown 9 ☐ Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 University Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA 2 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🚾 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2007 18, 4:10 A<sup>M</sup> Caroline V. Smith Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Counfy of Death Examiner Gilchrist Center Towson Baltimore 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🛛 F 146-26-8937 76 26, Director Nov. 1930 PA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rai", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 21044 5210 Cedar Lane Apt. 102 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Ā Specify 3 ☐ Widowed 4 🛭 Divorced white white Year or Dates "natural", Completed Health and Mental Hygiene. em 27 Is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Frederick Vieser Joan Kenworthy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I other tra Elizabeth B. Kelly - Daughter 12700 Maryvale Crt. Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Jan. 19, 07 Baltimore, MD 21. Signature of Funeral Service Licenses <sup>2</sup>C Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road Baltimore, MD 2 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ens disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day 5 ☐ Other (specify) the 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has bage 2 s autopsy performe death? 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) WORFILE 1 Yes 2 100 2 ER/Outpatient 3 DOA ို 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1) Datural Injury within 24 hours and uccor.

To the Funeral Director: After concluded the function of the further than the fu 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No € ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

JAN 2

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completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

07-00380 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Audrey E. Suter 1- For State Certificate of Death Rea, No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Deat Physician/ Month Day January 13, 2007 1630 hrs Audrey Elizabeth Suter Medical Examiner 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 4109 Echodale Avenue 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Months Davs Hours Director Country) 219-12-9873 2 X F FEB 13. 1923 М 83 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 No or items 23a or 28a-f show N/ABaltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. rector 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 4109 Echodale Ave 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Never Married Yes 3 X Widowed 4 Divorced If Yes, Give Year Yes 2 X No spacify: Specify: White marked other than "natural", c event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12 Clerk Rail Road 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert T. Cook Ethel E. Pape 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie Bollin/Cousin 5447 Whitwood Rd Baltimore, MD 21206 Baltimore, N permit. Pages I and Department of Healt Important: If item 20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Metro Crematory, Inc 1/18/07 Baltimore, MD Donation 5 Other Specify <sup>22</sup> Name and Address of Facility Cremation Society of Maryland, 21. Signature of Funeral Sarvice Licensea C. Todd Dring 299 Frederick Rd Baltimore Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequenca of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi ician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live hirth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown Linknown 23e. Did tobacco use contribute to the cause of death? P.O. contributing to death but not resulting in the underlying cause given in Part I þ Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? Yes 2 V No 26 Place of Death (Check only one) 25. Was case referred to medical Other<sub>4</sub> examiner? Hospital: 1 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 1 ✓ Yes No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 1 🗸 Natural 1 Yes 2 No Pending Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Che

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

and manner stated

Assistant Medical Examiner

Registrar's Signature

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Name and address of person who completed a usa of death (Item 23a)

29b. Signature and title of certifie

Susan Hogan MD. 31. Date filed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 14, 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 7

1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 19<sup>Day</sup> 2007<sup>Year</sup> January 6:05 P м Physician Marie Estelle Simoson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Manor Care 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Social Security Number Months Days **Funeral** Hours 1 M 2 X F 97 April 9. Maryland 212-70-9318 Director Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Broaue York Pennsyl vanila Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 17309 13770 Ted Wallace Road Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2**X**☐ No Specify: White Baltimore, Maryland 21215-0036 Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Joyner John Voat 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau 13770 Ted Wallace Road Brogue Pennsylvania 17309 Cynthia Simpson/Daughter in Law Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore Maryland 1/24/07 Gardens of Faith Leonard J. Ruck, INc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) yeavs' **Physician** Dementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Month Year in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4☐Pregnant at time of death Yes ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I \$ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a. Was an autopsy , page 2 certificate has performed? Yes 2 2 110 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 42 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or completely filled in by the funeral directors. 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide determined 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Jan, 22, 2007 D0061199 es and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57, Suite 209, Towson MD 21204 North Charles Jason Black, 6565 31. Date filed (Month, Day, Year)

JAN 2 3 2007 , Registrar's Signature State Registrar

Records, P.O. Box 68760, SIMON NICHOLAS Division or Vital

18,

JANUARY

Baltimore,

State

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

2300 DULANEY VALLEY RD.

32 Registrar's Signature

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

TIMONIUM, MD 21093

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 100 P M SEVERN EVELYN 2007 JANUARY 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital
ecurity Number 6. Sex 7. Age (In yrs. Ia) altimore If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
FEB. 7,1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🕽 F VIRGINIA 85 212-16-9122 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at 1 X Yes 2 □ No Director MD. N/A BALTIMORE the t 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a or 2359 BOSTON STREET 21224 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. Wher then "neturel; or Ite 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No Specify: ۾ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CLINICAL STUDIES MEDICAL othert permit. Pages 1 end 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Is marked other eny Injury or other treumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be N/A GODWIN HELEN в. N/A9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TODD SEVERN/GRANDSON 4932 JENKINS LANE, BALDWIN, MARYLAND 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation - 5 ☐ Other (Specify) BAYVIEW CREMATORY 1/19/07 BALTIMORE, MARYLAND 21. Signature of Funeral Santce Licensee ZILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COLLADSE HEMODYNAMIC DAYS /Medical Due to (or as a consequence of): Examiner SEDSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit BayEL ISCHOMIC Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 4 Pregnant at time of death ed by the detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🖺 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA this After this funeral c 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending Injury death. 1 TYes 2 No investigation after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital within 24 hours a To the Funeral C Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) RES-404 WD JANUARY 30. Name and address of pers ocompleted cause of death (Item 23a) (Type, Print) JOHN GEODGE APOSTOLINES 600 NORTH WOLFE STREET BALTIMORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 3 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 50 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:32 PM Jean Shilow TAN 200+ 9 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SAINT AGNES n/a HOSPITAL 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Min Months 1 □ M 2 1 F 212-28-7558 74 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Glen Burnie Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 500 Winton Avenue 21061 Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White Specify: þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Insurance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Harvey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health ar Important: If item 27 Is 500 Winton Avenue, Glen Burnie, Maryland 21061 Barton R. Shilow, Jr. / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or 4 Donation Month (Specify) Entombrent Glen Haven Mem. Pk. 1/23/2007 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 'n 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) REFRACTORY SEPTIC Physician DAYS /Medical Due to (or as a consequence of): Examiner ERITONITI DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to (or se a consequence of) Examiner COLONIC DIVERTICULITIS/ISCHEMIA HOURS ERFORATED Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by t page 2 should be detach law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform The Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours at Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 2 19384 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S CATON AVE. BALTIMORE, MD. 21229 FRANCO. GUSTAVO 32. Registrar's Signat 31. Date filed (Month, Day, Year) State JAN 23 2007 Registrar

DHMH 17 Rev 1/2001

HILLOW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day EUGENE A. SATTLER 9:59 AM M 2007 January 19, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 06/26/1918 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 216-14-0172 Director MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No MD BALTIMORE Director MONKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 824 CORBETT RD 21111 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No f Yes, Give Year or Dates: ✓ 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: WHITE à 3 Widowed 4 Divorced natural", permit. Pages 1 and 2 should be filed within 72 ho
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur.
any Injury or other traumatic event, the Medical E
once. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12YRS College (1-4or 5+) FARMER FARMING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be G. WILLIAM SATTLER II ALICE WOLFE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DELORES SATTLER(WIFE) 824 CORBETT RD MONKTON, MD. 21111. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) NEW CATHEDRAL 01/22/2007 BALTO. CITY, MD. 21. Signature of Funeral Service Licensee d Address of Facility
W. JENKINS
YORK RD MO CO. 21111. INS & SONS COMONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** QQ55 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ HTI 1 Yes 2 No 3 Probably 4 Munknown di seaso Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 s page performed' certificate 1☐ Yes 2☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending F after death. After Injury 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director; A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Notertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Registrar JAN 2 3 2007

6565 N. Charles St

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Helen M. Gordon

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

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	3. Time of Death				
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VICOL	nico				
9.	Birthplace (State or Foreign				
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	Approximate Interval Between Onset and Death				
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Year

Day

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Gordon Leo Seibel anuary 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. ( **Examiner** gional medical Center If Under 24 Ars. Year Days Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Hours Min. 1 M 2 □ F 08/15/194 Director 219–40–5599 63 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, it is Medical Examinar must be notified at Directo MD Wicomico Willards 10f. Zip Code 10g. Citiz 10e. Street and Number 7411 West Holland Avenue 21874 Uni death by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kir al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be I Health and Mental Gordon L. Seibel Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or 19a. Informant's Name/Relationship (Type, Print) 7411 West Holland Avenue, Willard Lois M. Seibel (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department importent: If eny injury o Loudon Park Cemetery 01/22/2007 4 ☐ Decation 5 ☐ Other (Specify) 22. Name and Address of Facility permit. of Funeral Service Licensee atum Hubbard Funer 4107 Wilkens Avenue, Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as t IF FFMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ as been si Be Completed 24a. Was an autopsy certificate ha performed' diabetes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient R/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number

23e. Did tobacco use contribute to the cause of death? 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 0

Month

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)-

ww

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. < 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** SMITH 19:33 M 12,2007 DEWEY JANUARY /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE HOPKINS HOSPITAL THE JOHNS If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 □ F Director 213–42–3626 63 04/14/1943 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dieal Examiner must be notified at 1 X Yes 2 □ No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2308 SOUTHERN AVE Funeral 21214 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify Specify: WHITE 2 3 Widowed 4 Divorced Completed r than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9TH MECHANIC AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLEVE W. SMITH EDITH I. STOUT ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLEO PERDUE 2308 SOUTHERN AVE., BALTIMORE, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hi
Important: If iten
any Injury or oth
once. 5500 O DONNELL ST 1 ☐ Burial 2 DC remation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) BAYVIEW CREMATORY 01/18/2007 BALTIMORE, MD 21224 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part. Inter the disease, or conflications that caused the d shock, or heart failure. List pt one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** ENDOCARDITIS 1 MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or murry that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No Hospital: 1 inpatient ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Khi Nack, MD RES - 000 JANUARY 12,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOLFE STREET, BALTIMORE, MD RAKHI 000 NORTH NALK 31. Date filed (Month, Day, Year) State

Registrar

JAN 2 3 2007

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e, .	Physici		Harmon Lee Shaw				January	16, 2007	5:50P M
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	1
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E.	Funeral Director		150 450	rs. last birthday) 33 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 20	Year) 1923 III	place (State or Foreign intry) inois
			Usual Residence of Decedent				DCC: 20	, 1725 111	
	arylar show	-		City, Town or Lo	_				10d. Inside City Limits 11√2 Yes 2 □ No
	the M	ecto	Maryland Montgomery  10e. Street and Number	Saithers	10f. Zip Code		10	g. Citizen of What Cou	21
	3a or	O T	419 Russell Avenue, #520		20877			United Sta	-
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ary	2 should be and Mental is marked sumatic ev	T <sub>0</sub>	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street		9	City or Town, State, Z	ip Code)
	and 2 lealth a m 27 is		Susan S. Barton/Daughter	_	44. 4			g, Marylan	
Baltimore,			7	o. Place of Dispo cometery, crei Ontgomer	osition (Name of matory or other place V	<sup>(a)</sup> Janua	ry 19,	20c. Location - City or 1	
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75.	<i>j</i> . 4		23a. Pant. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	ath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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Ä	The ate h page	Com	Congestive heart faile	use.	Anem	ia	perform	ned? death? □No 1 □ Yes	2□ No
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Division of Vital	or Atter de Directer in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospitel or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di		29a. Certifier 12 Certifying Physicien: To the best of my	cnowledge, deat	th occurred at the tin	ne, date and place,	and due to the ca	use(s) and manner as	stated.
	n 24 h	edical	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated.	ination and/or in	ivestigation, in my o	pinion, death occur	red at the time, da	ite and place, and due	to the cause(s)
	To t	Σ	29b. Signature and title of certifier		29c. Licens			ed. Date signed (Month)	
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1	10+1		J. Robert Birechler  30. Name and address of person who completed cause of death (I LROBERT BIRSC HBALL),	tem 2≛) (Type, WA	Print) 201 641	KUSSE L. TTHERSB	CLRG, N	LB 2007	'7
347	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Si	nature	18 B				
	Regist	rar	Onit & O LEGIT JURGETTE JO	St. St. Asterna	3 Charles				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Gregory S. Sullivan January 2007 1751 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or F. Country)
April 20,1955 Washington, Birthplace (State or Foreign Country) **Funeral X**□M 2□F Director 220-60-3506 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Funeral Director 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 5218 Moorland Lane 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 7 is marked other than "natural", or iten traumatic event, the Medical Examiner 1 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Deliveryman/Volunteer Charity 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Robert B. Sullivan Leone Stevens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Robert B. Sullivan, M.D./Father 5218 Moorland Lane, Bethesda, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State January 21 1 ☐ Burial 2XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 2007 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee wil Blow M00803 | Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814-3

23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Physician food /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician as 1 attending properties of the pr IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiac Arrest Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown encephalopathy page 2 sl 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1X Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation choked while eating hamburner To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1/14/07 1 Yes 2 No 2 Accident 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) White Flint

Shown Mall

28f. Location (Street and Number or Rural Route Number of Town, State) 113U ROCKVIII

Maryland Septimber: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 30.1 Rockviile Pike 4 ☐ Homicide Marylane Kensington Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) F. Smonds, MO D036520

State

▶ William

William F. Simonds,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001 8600 Old Georgetown Road, Bethesda, Maryland

07

Melissa Stefanski

7-00258	 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legib
JNK UNK	 State of Maryland / Department of Health and Mental Hygiene

Maryland   N/A   Baltimore   1/X/ve   1/2   1/	te or yland City Limits 2 No
## Facility Name (if not institution, give street and number) ## G000 block of Washburn Avenue ## Baltimore  ## Under 1 Year   If Under 24Hrs   8 Date of Birth,MMDDYYYY   5 Birthplace (St. Unknown   1 m   2X   F   7 Age (if yrs. last birthdey)   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100	yland City Limits 2 No
Social Security Number   6   Sex   T. Age (in yrs. lisst birthdisy)   10   10   10   10   10   10   10   1	yland City Limits 2 No
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College (1-4 or 5+)   Cashier   Ca	
Dollard Steranski   Mary Williams    19a. Informant's Name/Relationship (Type, Print )    19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)    3612 Lilac Avenue   Baltimore, Maryland    20a. Method of Disposition    1	: 
Dollard Steranski   Mary Williams    19a. Informant's Name/Relationship (Type, Print )    19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)    3612 Lilac Avenue   Baltimore, Maryland    20a. Method of Disposition    1	
Shelly Stefanski / sister  Shelly Stefanski / si	
Physician // Medical Examiner  23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last  UNPENDED  AMENDED  22. Name and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between a consequence of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore, Maryland  Approximately Between and Address of Facility  4001 Ritchie Highway Baltimore and Facility  4001 Ritchie Highway Baltimore  4001 Page 18	7
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24a. Was an autopsy performed?  1	
Company and the standard of th	
a = 3 1 1/9a Centiler	)
29c. License number 29d. Date signed (Month, Day, Ye.	)
O.C.M.E. January 10, 2007	
30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day Year) AN 2 3 2007 32. egistrar's Signatur	

State Registrar 1)-16090

who completed cause of death (Item 23a) (Type, Print)
CR MD 3635 Old Court Rd Pinesu, 1/2 Mg 21208

29d. Date signed (Month, Day, Year)

1-19-07

and manner stated

2. Registrar's Signature

10

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Old Court ROAD Randallstown, Mb

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	1		30. Name and address of p	erson who c	ompleted cause o	f death (Item 2)	3a) (Type,	Print)											
-	6				V. Pat			D. 8	3903	Har	ford	Rd.	Bal	t.,	MD	21234			
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year GENEVIEVE J. TOWNES 0839 /Medical Januar 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Grenera 1aryland 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F Days Hours Min. 72 Yrs Director 32\_0336 NOV.15,1934 MARYLAND death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sl injury or other traumatic event, the Medical Examiner must be notified Director N/A MD, BALTIMORE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 n. Potomac ST. 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ xNo þ 3 Widowed 4 ☐ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) CHILD CARE PROVIDER SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental JOSEPH K. HANCE EVELYN TATE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RHONDA MCDONALD (daughter) 1723 JUDY LANE, EDGEWOOD, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Donation 5 ☐ Other (Specify) TRINITY CEM. JAN. 25, 2007 BALTIMORE, MD. Ignature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME PRESTON ST. BALTO, MD. 1412 E 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** tailur henal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit hronic and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death Month Day 5 Other (specify) detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2: autopsy performed? Yes 22 No certificate 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Yes 2 | 1 | No 1 4mpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

within 24 hours after death To the Funeral Director; completely

> State Registrar

29b. Signature and title of certifier

Antonio

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O

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Year

3

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M.D.

37. Registrar's Signature

29c. License number

land

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death 2. Date of Death 3. Time of Death

Amend #1, perMD, State of Maryland / Department of Health and Mental Hygiene 1 - For Ar State Ar Registrar 1. Decedent's Name (First, Middle, Last) Ruth Barbara Truitt **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fredesk 2842110 Home If Under 1 Year 7/Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🖾 F Months Days Hours Min Director 390-16-5790 July 28, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mentalle Hyglene. and the file and 28e or 28e-1 show anti: If tiem 27 is marked other then "neturel", or Items 23e or 28e-1 show ury or other treumetic event, the Madical Examiner must be notified at 10a State 10h County 10c. City. Town or Location Completed by Funeral Director Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Rosemont Avenue 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 N Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ Martha Anna Luebker Herman Carl Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Boute Number, City or Town, State, Zig Code) Roberta Pearl/daughter 56 Wenner Drive Brunswick, MD 21716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 2 Donation 5 ☐ Other (Specify) permit. D. Pleasant <sup>22. Name and Address of Facility</sup> State Anatomy Board Baltimore, MD 21201 21. Signature of Funeral Service I Anthony D. 655 W. Baltimore Street Mhony 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of): The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown

After death Director:

or Attending Physicien:

Fo the Hospitel within 24 hours a Medical Certific

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23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only or 2 Hospital: Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 Momicide 29a. Certifier

No. Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

ΠNo

5PM

10d. Inside City Limits 1 ☐ Yes 2 No

Approximate Interval Between Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

3 Probably

1 TYes

Year

4 Unknown

WI

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

X060 300

State Registrar

completely filled in by

			1 - For State Registrar  1. Decedent's Name	(Eight Middle Los	State of Ma			cate of		2. Date of D	Reg. No	2111	7 0	1520
	Physici /Medi		Karen Ly		•					Month -	Da - /-	7- 07		Time of Death
	Examir Funeral Director		4a. Facility Name (If In Frank / In 5. Social Security Num 217-64-20	Square 6. Se	HOSPITAL	(En Ki (In yrs. last)	birthday) If	City, Town, DOC Under 1 Year onths Days	If Under 24 Hrs	8. Date of B	inth	9	timor	ZE (State or Foreign
	and and		Usual Residence of D 10a. State	Decedent 10b. County		10c. City, To	own or Location	n					10d. Ir	iside City Limits
2	th the Marylan or 28e-f show	ctor	MD	Baltimo	re	Park	ville							□Yes 2 No
a R	ath with th 23a or 26 ust be no	rat Dire	10e. Street and Numb				1	0f. Zip Code 21234			10g. C	itizen of Wha	t Country?	
$\simeq$	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28e-f ehow ent, the Madical Examiner must be notilited at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:			Decedent of s, specify Cut	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - A Black, V Specify: W	Vhite, etc.	dian,
エストリータチのり, Maryland 21215-0036	within 72 hours ene. then "natural", ne Wadesi Ex	Completed	(Specify	15. Decedent's Education (Specify only highest grade completed)  Elementary(Secondary (0-12)   College (1-4or 5+)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Domestic						Kind of Busine eaning	sss/Industry Serv	ices		
(\(\int\)	₹ E S	To Be Co	17. Father's Name (F							me (First, Middle Billing				ı,
トロス)	4 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		19a. Informant's Nam			1:	9b. Mailing Ac 9 Acre	dress (Stree	tand Number or R Parkville	ural Route Numb	per, City	or Town, Stai	e, Zip Code	a)
	a 1 6 4			sition	Removal from State	20b. Place ceme Ches	of Disposition tery, cremator apeake	(Name of y or other pla Crema	nce)	<sup>Day</sup> an 20 . 2007	20c. L Be	ocation - City		
Balti	permit. Pages Department of P Important: If tte any injury or of		21. Signature of Fund	eral Service Licen	soo uttu M	0(44=	²€¥ê 871	mation 7 Gree	esanderWner n Pastures	al Alter Drive	nati Balt	ves imore,	Maryla	and 21286
•00	Physician /Medical Examiner prize and prize transit	ledical Examiner	23a. Part 1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)  Sequentially list condition and the sequentially list condition and the sequentially list conditions. Enter Under Cause (Disease or in that initiated events resulting in death) La	ditions, nediate (ing jury	b. Due to (or as a Due to (or a)	bar consequence hooi consequence holis	Pne e of): 5 Of t e of):	a mode of dy		c or respiratory a	arrest,		Ons	oximate val Between et and Death 2 U S
P.O. Box 68760,	The law requires that the death certificate be executed tte hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 9 □ Unknown	onths?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetal dea		pic pregnancer (specify)	:y			23d. Date of Month	delivery Day	Year
rds, P	w requires that been signed to should be deta		Part II. Other signific	ant conditions co Blee (	ontributing to death bu	t not resulting	in the under	ying cause gr	ven in Part I.		lobacco Yes 2	use contribut	e to the cau	47
Division of Vital Records,		Completed by								24a. Was auto perfe 1 X Yes	psy ormed?	death	autopsy fir to completi 1? /es 2 1	ndings available on of cause of
fVit	S D	To Be	25. Was case referre examiner? 1 ☐ Yes 2 Ø N	1	Hospital:	nt 2 ER/0	Outpatient 3	□ DOA Ot	hon	ath <i>Check only</i> Home 5 ☐ Resi	100	6 □Other (S	ipecify)	
sion o	fer fler		27. Manner of Death   Manual   S   Pending   2   Accident   Investigation   In											
Divis	or Att	Medical Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, . (Specify)	farm, street, f	actory, office		28f. Location ( City or To	Street ar wn, State	nd Number or e)	Rural Rou	e Number,
St.	the Hospital nin 24 hours of the Funeral in pletely filled	edical	29a. Certifier 1 (Check only 2 one)	Certifying Phy	ysician: To the best o niner: On the basis of and manner stat	examination a	ge, death occ and/or investig	urred at the ti pation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s date an	) and manner d place, and c	as stated. due to the c	ause(s)
	To the Company	Ž	29b. Signature and tit	le of certifier	2 1 100	N		29c. Licens	se number		29d. Da	te signed (Me	1	
			30. Name and addres	s of person who o	completed cause of de		(Type, Print)		Squar	n Dali	, 72	01/13		
	Sta Registr		31. Date filed (Month	2°3 2007	32. Registra	r's Signature	best 1	nKlir	1 Squar	e Ulive	LA	XI DMC	ire, M	16165/

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Helen 2007 12:05PM Inompson 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number House Rockville Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 M 2 F 492-32-7873 Missour Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD montgonery 10e. Street and Number 10g. Citizen of What Country? 2409 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2XNo Specify Specify: 3 Widowed 4 Divorced black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Aline Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Daughter 1608 North Crest Dr. Silver Spring MD 20204 Thompson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City or Town, State Date Rockville, Maryland 11-23-07 4 □ Donation 5 □ Other (Specify) Parklawn Cemetery 22. Name and Address of Facility Rapp Funeral + Cremation Services 21. Signature of Funeral Service Licenses 933 Gist Ave Silver Spring, MD 20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Amyrophic L Due to ras a consequence of) Sequentially list conditions, Durity (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): s, outcome pf pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

show

ms 23a or 28a-f shov must be notified at

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'natural",

7 is marked other than "natu traumatic event, the Medical

Director

Funeral

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after death in nent of Health and Mental Hygiene.

Health a

Department of Health Important: If item 27 any injury or other tr

Baltimore, Maryland 21215-0036

Physician/Medical Examiner physician and the burial-transit as for use certificate has been signed by the rector, page 2 should be detached Be Completed by funeral director, Certification: To After this Director;

The law requires that the death certificate be executed

il or Attending Fafter death.

within 24 hours an To the Funeral D Hospital

To the

filled in by

Medical

Division or Vital Records, P.O. Box 68760,

	d
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If ye

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part

	] 140
24a. Was an autopsy	24b.
performed? 1□ Yes 2 No	

26. Place of Death (Check only one)

Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25.	Was case referred to medical
	examiner?
	1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

28a. Date of Injury (Month, Day Year) 5 Pending

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 Tes 2 No

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ★Other (Specify) → Spi CO 28d. Describe how injury occurred

29a. Certifier (Check only one)	1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier nthin m Allions Do

6 Could not be determined

29c. License number H0058032 29d. Date signed (Month, Day, Year)

1-19-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Rd, Rockville, MD 20855 Williams D.U. 31. Date filed (Month, Day, Year) JAN 2 3 2007

State Registrar

			For State Registrar	State of Ma	arylan			t of H			tal Hygi	ene ()	7	01522
			1. Decedent's Name (First, Middle, Last)						_	2. [	Date of Death			3. Time of Death
	Physici		Joseph	Clarkson	Th.	ackery					<sub>Month</sub> anuary	Day 19, 20	Year 07	7:40 A M
	/Medio Examir		4a. Facility Name (If not institution, give s				4b. City.	Town, or	Location of D		andary	4c. County		7.40 A
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	Funeral		Social Security Number 6. Sex		e (In yrs. I	ast birthday)	If Under		if Under 24	Hrs. 8. [	Date of Birth Month, Day,	11011	tgon 9. Birtho	
н	Director		316-10-9224 <sup>1</sup> X	IM 2□F	92	Yrs.	Months	Days	Hours N	Min. (	Month, Day,	<sup>Уваг)</sup> 18, 1914	A rl	place (State or Foreign ntry) Cansas
			Usual Residence of Decedent										4111	.ansas
	rylan how	,	10a. State 10b. County		10c. City	, Town or Lo	cation						1	10d. Inside City Limits
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	라 5g 라	lre	10e. Street and Number				10f. Zip	Code			10	g. Citizen of W	hat Coul	ntry?
	23a	al	14400 Homecrest	Drive, #2	47			2090	6		1	United	Stat	es
	e E	nei	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. V	Vas Deced	ent of Hi	spanic Origin? n, Mexican, Pi	? (Specify	Yes or No-		- Americ	can Indian,
9	or It	by Funeral Director	1 Never Married 2 Married	1 ☑ Yes 2 ☐ I If Yes, Give	NO WW	TT	□Yes 2		Specify:		.,,	Specify:		
21215-0036	ural'.	d D	3 ☐ Widowed 4 🖾 Divorced	Year or Dates:								Opecity.	W	hite
<u>v</u>	nat	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced (Give	kind of wor	k done d	uring most of	working	1	6b. Kind of Bus	sin <i>e</i> ss/In	dustry
2	han ithir	Ę	Elementary/Secondary (0-12)	College (1-4or 5	i+)		OO NOT us	e retirea)				_		
20	Hygie nt,	ပိ	17. Father's Name (First, Middle, Last)	5+		Atto	rney		18 Mother's	Name (Fir	st Middle M	Law aiden Sumame	-1	
ano	ntal l	Be		0.015.0									3)	
2	houk d Me mark mati	ဥ	James William Tha			10h Mailin	a Address	(Ctrant o			arkson		3	Code) 90065
<u>s</u>	d 2 s th an th an 7 ls trau		Jonathan P. Thacke	•		1.								
o o	Heal Heal em 2		20a. Method of Disposition	1 y / 3011	20b. Pl							Oc. Location - (		lifornia
ō	nt of		1 ☐ Burial 2 MCremation 3 ☐ Re	emoval from State	i	ace of Dispos			I	muary 2007	-			
Baltimore, Maryland	nitan njun		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeyal Service Libense		Mone	gomeryC			1			ethesda		
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If them 27 is marked other than "natural, or lieme 23s or 28e-f show any Injury or other traumatic event, the Madical Examiner must be notified at Once.		Mugelettelan	net -	M013	755	/ Wisc	onsir	Avenue	, Beth	esda, M	aryland 2	nevy (20814-	Chase, Inc. -3501
П			23a. Part1. Inter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each lir	the death	. Do not ente	er the mode	of dying	, such as card	diac or res	piratory arres	st,		Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	ACUTE	N	YOCI	2RDI	AL	INF	ARI	TINA	1		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	3,,,,,		00,00	11100	77010			
	LAdminei		Sucuentially list conditions b.											
/	p	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):								
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	physi physi the t	dlcal	d.					-					-	
9 ×	death certifica	Me	IF FEMALE:	Sc. If yes, outcome	of preenar	2011								
Вох	atten for u	au	in the past 12 months?	1 ☐ Live birth	2 □Fetal	death 3	Ectopic pre					23d. Date Mont		ory Day Year
o i	by the a	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at 9 Unknown	ume or de	am 5⊔	Other (spe	сту)						,
٠.	requires that the veen signed by th hould be detache		Part II. Other significant conditions conf	inbuting to death bu	ut not resul	Iting in the un	derlying ca	use dive	n in Part I		23a Did toba	ICCO USA CONTRI	oute to th	e cause of death?
Sp.	that that signed by the details and the detail	Completed by	atial sibuillation	en 1910s	201	ino ha	Ret	Di.	0,00					ably 4 Dunknown
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Records,	has has	g.	Collegeon, per	mark	Jol	, 601	v g) on	mus	2 por	lue!	24a. Was an autopsy perform	24b. W pr ad2 de	ere autor ior to cor eath?	osy findings available apletion of cause of
	certificate		(Monu of the	uline 1	yer	nono	m Olls	Reg	٥	-	☐ Yes 2	No 1	∃ Y <i>e</i> s	2 □ No
<b>\bar{\bar{\bar{\bar{\bar{\bar{\bar{</b>	Physicia this certi ral directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	ospital:					26. Place of D					
ō	rald	- A	27. Manner of Death	1 ☐ Inpatie		R/Outpatient 28b. Time of		A Inuny	4 Li-Nursing			ce 6 □Other		1)
ا ا	th. : After funer	힐	1 D Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year)	Injury	м	lc. Injury Work'	es 2 □ No	200.	3000.120 1101	injury docume	•	
Division of Vital	Attending Physician: It death. ector: After this certifica by the funeral director, I	t Ca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ıry - At hor	n <i>e</i> , farm, stre				28f. L	ocation (Stre	et and Number	or Rura	l Route Number,
á,	safter safter el Dire	Certification:	4 Homicide	building, etc	. (Specify)					6	City or Town,	State)	0, 1,0,0	, , , , , , , , , , , , , , , , , , , ,
	lo the hospital of Attent within 24 hours after deat To the Funerel Director: completely filled in by the I	edical (	29a. Certifier 1 Certifying Physical Examination (Crieck City one)	cian: To the best of er: On the basis of and manner sta	examinati	vledge, death on and/or inv	occurred a estigation,	t the time	o, date and pla nion, death or	ace, and d	ue to the cau the time, dat	se(s) and man e and place, ar	ner as st	ated. the cause(s)
	within 2 To the comple	Me	29b. Signature agid title of certifier	stanfor sta			29c.	License	number		290	. Date signed	(Month, I	Day, Year)
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	1	1	30. Name and address of person who con	anlated	WY)	, M )			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
19	711		Anuradha Arun, M.					S1	iite 20	)9 . c	ilver	Spring,	MD	20902
9	Sta	e_	31. Date filed (Manage Page) 2007			ite Total		, DC		. د و د	TTAGE	nht tiig,	FID	20302
	Registra		2414 5 2 KING	JUST CAR	15	Spa	and the second							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 19, 8:05 A M ERNESTINE TENNENBAUM 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOWARD COLUMBIA HARMONY HALL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months 0672171909 1 □ M 2 🔽 F 97 Director 128-30-1988 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ms 23a or 28a-f shov must be notified at 1 X Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21218 3601 GREENWAY #505 Funeral Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items any injury or other traumatic event, the Medical Examiner magnee. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: Specify: Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHAYES LEA ROSENBAUM JOSEPH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 GREENWAY #505 - BALTIMORE, MD 21218 RUTH SHEIN / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State CEDAR PARK CEMETERY 01/21/2007 EMERSON, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Inter the disease, or complications that caused the death. Do not enter the mode of dying, shock or heart failure. Lisy only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents.) Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 XÑo Certification: To 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

10

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 3

30. Name and address of person who completed cause

2007

32. Agistrar's Signature

aturé S Agasti

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Wilbure E. Wolff 1/18/07 2:05 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brooklyn Park

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Genesis Elder Care Anne Arundel Co. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F 81 Director 217-12-0116 5/17/1925 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "netural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Reavis Road 21076 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White ģ 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Manager Auto Body Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi h and Mental H 7 le marked of Wilbure C. Wolff Louise Bumbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health a. Important: If Item 27 le eny Injury or other trac Allen Lambert/Nephew 113 Reavis Road, Hanover, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 1/19/07 Elkridge, MD 21. Signature of Funeral Seprice Licenses 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 lockions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, he cause on each line. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Presmonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Feilure Congestive Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division of Vital Records, P.O. Box 68760, use as the burial-transit led by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Dementin 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No After this certification or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending To the Hospitel or Attendir within 24 hours after death.
To the Funerel Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No death investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0064624 January 19, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ockwood Rd. #101 , Glen Bornie, MD 21061 SANDEEP SHARMA 7845 31. Date filed (Month, Day, Year) 3 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

	For State Registrar		partment of Health and Nertificate of Death	Mental Hygier	2007 01525
Physiciar /Medica	Lia Lace Mode	Last)		2. Date of Death	Day Year 2007 6:30 A M
Examine	4 200 500 00 000 000 000 000 000	give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	417 Wheaton Pla	ace Apt. E. Sex 7. Age (In yrs. last birthd	Catonsville  If Under 1 Year If Under 24 Hrs.	O Date of Birth	Baltimore
Funeral Director	217-18-0862	13CMM 2□ F 86 Yrs	Months Days Hours Min	8. Date of Birth (Month, Day, Yea May 20, 1	9. Birthplace (State or Foreign Country)  920 Maryland
2	Usual Residence of Decedent			ray 20, I	720 Flatytaliu
arylar show	10a. State 10b. County	10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	MD Balting 10e. Street and Number	ore Catonsy	7ille 10f. Zip Code	10a (	Ditizen of What Country?
3a or	គឺ 417 Wheaton Pl	ace Ant E	21228		
death	417 Wheaton Pl 11. Marital Status 1 □ Never Married 2 ▼ Marrie		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		USA 14. Race - American Indian,
after after		1	1 ☐ Yes 2 ☐ No Specify:	nican, etc.)	Black, White, etc.  Specify:
be filed within 72 hours after death with the Maryland hall Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:		ite	white
21215-0036  ed within 72 hours af  er than "natural", or  the Medical Exami	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	ive kind of work done during most of work  e. DO NOT use retired)	ing 100.	Kind of Business/Industry
212 ad with giene er tha , the I	Elementary/Secondary (0-12)	a'	veyor	En,	gineering Co.
nd be file tal Hy d oth d oth	17. Father's Name (First, Middle, La	est)	18. Mother's Nam	e (First, Middle, Maide	
Aarylanc 2 should be f and Mentall 1s marked of raumatic ever	o Alvin Wode		Marie Be		
Maryland nd 2 should be file alth and Mental Hy 27 is marked oth ir traumatic event	19a. Informant's Name/Relationship  Ruth E. Wode -		ailing Address (Street and Number or Rui		
	20a. Method of Disposition	20b. Place of Dis	Wheaton Place Apt sposition (Name of		SVIIIe, MD 21228 Location - City or Town, State
	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Hemoval from State	rematory or other place)  rematory  Jan.	22 O7 Bo	ltimore, MD
	21. Signature of Funeral Service Li	12,002,0	22. Name and Address of Facility		ALTERNATION OF THE STATE
0 83E 8 8	1 km 11	acher	Cremation Society 299 Frederick Road	of Marylai Baltimore	nd, Inc e, MD 21228
&	snock, or near failure. List of	omplications that caused the death. Do not ally one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	a. ISCHEMIC CARDI	UMYUPATUY		year
Examiner		Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate cause. Linter Uncertying Cause (Disease or injury	b. Due to (or as a consequence of):			
executed ial-transit	Cause (Disease or injury that initiated events resulting in death) Last	с			
8760, Co		Due to (or as a consequence of):			
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HOX 6	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy			23d. Date of delivery
o decition and for ed for	in the past 12 months? 1 ☐ Yes 2 ☐ No		3 □Ectopic pregnancy 5 □ Other <i>(specify)</i>		Month Day Year
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al Hecords, P  : The law requires that cate has been signed t page 2 should be dere		Car 1/1/1/1-1/1/1		()	
The laverate has page 2				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
VItal Records, sician: The law requires to certificate has been signer rector, page 2 should be on the completed by			26. Place of Deatl	1☐ Yes 2 🗹 N ∩ (Check only one)	lo 1 □Yes 2 1 No
_ S s 5 C	1 Yes 2 10	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Other		6 ☐Other (Specify)
On O		28a. Date of Injury (Month, Day Year) 28b. Time	y Work?	28d. Describe how inj	ury occurred
DIVISION  I or Attending after death. I Director: Afte d in by the fune	2 Accident investigat 3 Suicide 6 Could not	be   200 Place of injury At home form	M 1 Yes 2 No	206 Logation (Ctoort	
2 p # 2 = 1	4 ☐ Homicide determine	building, etc. (Specify)	street, factory, office	City or Town, Sta	and Number or Rural Route Number, te)
Hospital Hospital Hospital Hospital Hospital Hours a Humeral I		Physician: To the best of my knowledge, de	eath occurred at the time, date and place,	and due to the cause(	s) and manner as stated.
the Hosp hin 24 hot the Fune npletely fi		aminer: On the basis of examination and/or and manner stated.		red at the time, date a	nd place, and due to the cause(s)
To t To t com		0 10	29c. License number		ate signed (Month, Day, Year)
	V	a Gallagan, Mo			N. 22,2007
3	Laurence (	o completed cause of death (Item 23a) (Typ Pallagen MD 7	16 Maider Choice	e tane.	Baltinore md DIDS
State	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Carle 10		/
Registrar	JAN 2 3 2	1007 Believe Di Py			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Arthur J. Weiss January /Medical 16 2007 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 11XM 2□ F 09/12/1937 69 Director 214-34-3078 Yrs Mary Tand Usual Residence of Decedent death with the Maryland 10a. State 10b. County item 27 is marked other then "natural", or items 23s or 28s-1 ehow other traumatic event, the Medical Exacts are must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2901 Rueckert Avenue Completed by Funeral 21214 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Teletype Repairman C&P Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental F Arthur Jacob Weiss ဂ္ Sarah Margaret Parthree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Carolyn Weiss, Wife 2901 Rueckert Avenue, Baltimore, Maryland 21214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Hilltop Service Corp. 4 □ Donation 5 □ Other (Specify) 01/22/2007 Towson, Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee 5305 Harford Road, Baltimore, MD 21214 Cleyandras 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Restiratory **Physician** ailure /Medical Examiner Secondanie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physicien: The law requires that the death certificate be executed physicien ar s the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: BSI. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a I be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed Embolism lmonar 1 Yes 2 - No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manyer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendin within 24 hours effer death.
To the Funeral Director: Alt completely filled in by the fun 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES DOO 01,16,2007 son who completed cause of death (Item 23a) (Type, Print), 5601 LOCK Raven Blvd, Baltinuone MD 21239-2995 ANKAJ KAW, 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

		·	For State Registrar	State of Marylan			nt of He te of D			giene	7 01528
	Physici /Medic		1. Decedent's Name (First, Middle, Last	WASHB	UZN	)			2. Date of De Month	Day Y	ear 1232 A
). N	Examin Funeral		4a. Facility Name (If not institution, give  Genesis - Brighty 5. Social Security Number 6. Se	vood x 7. Age (In yrs.	last birthday)	L If Unde	uther	ville If Under 24 H	Irs. 8. Date of Bir	4c. County of Baltin	
	Director		168-03-3289  Usual Residence of Decedent  10a. State  10b. County	M 2□F 90	Yrs.	Months	Days	Hours M	Feb 8,		ennsylvania
	death with the Maryland ms 23s or 28s-f show rnuel te notified at	Director	Maryland Baltimo		Timon	ium	p Code			10g. Citizen of Whi	1 ☐ Yes 2 🌠 No
36		by Funeral Di	408 Kilree Road,  11. Marital Status  1 □ Nøver Married 2 M Married  3 □ Widowed 4 □ Divorced	#302  12. Was Decedent Ever in U. Armed Forces?  1 Styles 2 No If Yes, Give Year or Dates: 1942-		Vas Dece	cify Cuban	panic Origin? , Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		American Indian, White, etc.
Maryland 21215-0036	filed within 72 hours after Hygiene. other then "naturel", or Ite ent, the Medical Exemine	Completed	15. Decedent's Education State (Specify only highest grace Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)	Education grade completed)  College (1-4or 5+)  16a. Decer (Give life.)  S			ork doné di ise retired) man	aring most of w		0.	Ventilation
arylanc		To Be	William C.  19a. Informant's Name/Relationship (7)	Washbu	-			E11a	a	G。 er, City or Town, St.	Ewing
altimore, M	es 1 end of Health fitsm 27 r other tr		Harriette S. Wasł  20a. Method of Disposition  1 \( \mathbb{X}\) Burial 2 \( \mathbb{C}\) Cremation 3 \( \mathbb{E}\)  4 \( \mathbb{D}\) Donation 5 \( \mathbb{O}\) Other (Specify,	20b. P Removal from State	lace of Dispo emetery, cren	sition (Na natory or	me of other place	1/2	2, Timoni 25/07 Gardens	20c. Location - Ci	1-4
Baltir	permit. Pag Department Important: B sny Injury o		Bryan W. Clary	laxy	22	. Name a Leтии 10 W	nd Address on Fu	of Facility Neral i Onia Ro	dome of Dome of Dome	ulaney Va nium, MD	m, Maryland lley Inc. 21093
J.	Physician /Medical		23a. Part1. Enter the Isease, or comp shot, or heart fallure. List only o Immediate Cause (Final disease of condition resulting in death)	a. Caralis	ic a	er the mo	1 1	, such as card		rrest,	Approximate Interval Between Onset and Death
8760,	Examiner and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of): (	og	rett	5			YEARS
O. Box 6	ath certific titending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of di 9□ Unknown	death 3	Ectopic p	oregnancy pecify)			23d. Date of Month	
Δ.	w requires that the de been signed by the a should be detached to		Part II. Other significant conditions co	ntnbuting to death but not res	ulting in the ur	nderlying	cause give	n in Part I.			ute to the cause of death?
al Reco	: The law receive has been page 2 sho	Completed by	LYMPHOMA	-						osy prio	ore autopsy findings available or to completion of cause of ath? I Yes 2 ☐ No
Division of Vital Records,	Attending Physician: The la sr death. sctor: Atter this certificate has by the funeral director, page 2	ıtlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Mannar of Death  1  Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 Inpatient 2 Robert (Month, Day Year)	ER/Outpatien 28b. Time of Injury		OA Other 28c. Injury Work	. 4 Nursing		one) dence 6 Other how injury occurred	
Divisi	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifi	ome, farm, stre	eet, facto	y, office		28f. Location ( City or To		or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	one)	rsicien: To the best of my kno iner: On the basis of examina and manner stated.	wiedge, death tion and/or inv	estigation	n, in my opi	inion, death oc	ace, and due to the courred at the time,	date and place, and	d due to the cause(s)
)	To Too	2	29b. Signature and title of certifier  F. Sebed	e (MD		29	COE	717	<i>p p</i> = 1	29d. Date signed (1)	Month, Day, Year)
	4+1 Sta	te	30. Name and address of person who company the state of t	ompleted cause of death (Item DENGA 40  32. Registrar's Signa	MY	Print)	670	1 N	LIMPUE	55750	12007 WD. VENECA DITE A202 MD 21204
	Regist		31. Date fled (Month, Day, Year)	Silver St. B	ALL D						•

DHMH 17 Rev 1/2001

07-00434 Lisa Wright

1- For State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 01529

		Registrar OCITITICATE OF DE	catii	Reg	g. <b>N</b> o.						
Physici Medical Exam		1. Decedent's Name (First, Middle,Last)  Lisa Kay Wright	Date of Death     Month     January 16		3 Time of Death 0657 hrs						
			city, Town, or Location of Death		4c. County of Death N/A						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthp									
Director		214 88 6113 <sub>1 M 2</sub> X <sub>F</sub> 43 <sub>Yrs.</sub>	Months Days Hours Min		Foreign						
ž:		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				1011					
Maryland 28a-f show any d at once.	'n	Maryland Anne Arundel Baltimore	e			10d Inside City Limits  1 Yes 2 X No					
1aryla 28a-f Lat oo	Director	10e. Street and Number 10f	f. Zip Code	10	g. Citizen of What Coun	try?					
ith the Maryland 23a or 28a-f sho notified at once.		227 Doris Avenue	21225		U.S.A.						
eath wit items?	Funeral	1 Never Married 2 Married Armed Forces? If Yes, s	ecedent of Hispanic Origin? ( Specify Cuban, Mexican, Puerto		14 Race - Americ White, etc.	an Indian, Black,					
after de al", or ner mu	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	s 2 X No specify:		Specify: V	White					
nours a		15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Us	sual Occupation (Give kind of volume of working life, DO NOT use reti		16b. Kind of Business/In	dustry					
10re, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. t: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12th Homema		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Own Home						
5-0 iled w Hygie d othe		17. Father's Name (First, Middle, Last)	18.Mother's Name		,						
21215 ould be filt Mental H marked ic event, t	Be	John Clapp		bara Gra							
MD 21 d 2 should 1 lth and Mer n 27 is man	ို		dress (Street and Number or F ris Avenue B		per, City or Town, State,  e. Maryland						
ore, MD 2 es I and 2 shou of Health and N If item 27 is n ther traumatic		20a Method of Disposition  1 X Burial 2 Cremation 3 Removal from State crematory or other pl	(Name of cemetery,		20c. Location - City or T						
Baltimore, permit Pages I an Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State Glen Haven M	dem. Park 1/2	22/2007	Glen Burni	e, Maryland					
Baltimo			and Address of Facility Gor Ritchie Highwa	nce Fune	ral Service	, P.A.					
		3a.) art Enter the diseas, or complications that caused the death. Do not enter the mo	Kitchie Highwa	y Balti	more, Maryl						
Physician /Medical		failure. List only on wuse on each line.		r respiratory arres	st, snock, or neart	Approximate Interval Between Onset and Death					
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Acute thrombosis of coronary Due to (or as a consequence of):	ry artery			Dodu					
	_	Sequentially list conditions, if any, leading to immediate  b. Atherosclerotic cardiovascu  Due to (or as a consequence of);	ılar disease								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated									
d d ansit	Exa	events resulting in death) Last  Due to (or as a consequence of):  d			1						
e executed sian and rial - transi	an/Medical	XUNPENDED	-969 1/95/97 FFF								
68760, ertificate be ding physici	Me	#23a-b.PII.27.perME.	_g803, 1/25/0/ T1		23d Date of delivery						
68760, sertificate be ding physic se as the bur		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal de	eath 3 Ectopic pregna	ncy	Month Da	ay Year					
i, P.O. Box 68760, ries that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	Physic	1 Yes 2 No 9 V Unknown  4 Pregnant at time of death 5 Other (	(Specify)								
P.O. I sthat the gned by the e detache	by Pt	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?					
S, P uires t an signo		Lupus erythematosis			2 No 3 Proba						
cords, law requir has been s	Completed		·	24a. Was ar autopsy	y prior to co	ppsy findings available mpletion of cause of					
tal Reco cian: The law certificate has ector, page 2 s	팃			perform 1 <b>V</b> Yes 2		2 No					
Vital   ysician: his certifi director,	Be (	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)							
F Vit Physic r this	2	1 V Yes 2 No Inpatient 2 V ER/Outpatient 3		-	esidence 6 Other:						
Division of Vital Records, tal or Attending Physician: The law requires after death all Director: After this certificate has been seled in by the funeral director, page 2 should it	io i	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	ow injury occurred						
isior Attencer death	ertification:	2 Accident Investigation 28e Place of Injury - At home farm street fac		28f Location (Str	reet and Number or Rura	al Route Number City					
Divisi pital or Ati ours after d teral Direct	ertii	Suicide  6 Could not be determined  (Specify)	,,	or Town, Sta		arroute Hamber, only					
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atternoppietely filled in by the funeral director, page 2 should be detached for u	cal C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a one)	at the time, date and place, and	due to the cause	(s) and manner as stated						
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.  29b. Signature and title of certifier	in my opinion, death occurred a  29c. License number								
			O.C.M.E.		29d Date signed (Mont January 17, 2007	n, Day, Year)					
of		30. Name and address of person who completed cause of death (Item 23a)	J.J.W.L.								
pera		Susan Hogan MD. Assistant Medical Examiner 111 Penn St	treet, Baltimore, MD 21	201							
Si Regis	ate trar	31. Date filed (Month, Pay, Year) 32. Resistrar's Signature	E)	•							

07-00552

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Shelby Wilson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Time of Deat Month Day January 20, 2007 **Medical Examiner** She1by 1602 hrs Wilson 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death University Hospital Baltimore N/A5. Social Security Number **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Director 212-42-2988 1 X M 2 62 Yrs 1944 May 24 Usual Residence of Decedent any 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show X Yes 2 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene N/LBaltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 2 must be notified 605 North Calhoun Street 21217 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. Yes 2 X No Widowed 4 Divorced If Yes, Give Yea Specify: Black Yes 2 X No specify. ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) marked other than Security Officer Becton Dickinson 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be She1by Wilson Antoinette Willis 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is m traumatic Janee Clark - daughter 6603 Laurel Drive, Gwynn Oak, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State tant: If i crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Donation 5 Other Specify Metro Crematory, Inc. 1/23/2007 Signature of Funeral Service Licensee 22 Name and Address of Facility of MD, Inc. Steven H. Williams M00986 299 Frederick Road, Baltimore 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Cerebellar hemorrhage Death Immediate Cause (Final disease Examiner or condition resulting in death) Hypertensive cardiovascular disease Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical physician a X UNPENDED AMENDED #23a-b,PII,27,perME, g863, Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live hirth Fetal death past 12 months? Month Day Year Pregnant at time of death Other (Specify 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Cocaine use, cirrhosis of liver 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA After this Nursing Home 5 Residence 6 Other 70 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No within 24 hours after death To the Funeral Director: Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O OCME January 21, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Carol Allan, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 32 Registrar's Signature

Registra

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Zella Physician Robert 2007 Vanuar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Holans AMONY Date of Birth (Month, Day, Year) (In yrs. last birthday Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours Min 1 M 2 □ F 57 272.46.5440 OH Director 04/03/1949 <del>MD</del> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Tes 2 No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21214 2107 Echodale Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 f Yes, Give Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: <u>}</u> If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Retail Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Sales or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental F ages 1 and 2 should bent of Health and Ments: If Item 27 is marked Emil Adam Zella Mary Jane Knezeak ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Allen Szymczak/Friend 4705 Roland Ave. Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ament of He 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Jan 20 Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2007 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) embolism pulmonary **Physician** two weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. East of Joseph Grause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. ng physician as the buria Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. livision or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an ate has page 2 s 1∏ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral in Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 doctor Medical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Omar Latif, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltinore, Maryland 21287

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2

3 2007

2. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Bernise Delisa Aiken-Hornbaker sanua /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 XF Director 219-46-2934 59 April 18 1947 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Marvland Washington Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21767 U.S.A. 14015 Village Mill Drive Apt. D3 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married $_{\it Specify:}$ White 1 ☐ Yes 2 ▼ No þ Specify. 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Food Processing Co. Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. is marked Mary Ada Hill Lester William Hornbaker ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Road Clear Spring Maryland 21722 Donna Lee Hose (sister) 11642 Dam 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory | 1-9-2007 Smithsburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Fuenral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician WA 0 /Medical Due to (or as consequence of): Examiner erehovosular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Tes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed' After this certificate 1∐ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1'Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: tely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 📡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

3H-L

within 24 h

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Jascem 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

1126 Opal Court 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Hagerstown Maryland

29d. Date signed (Month, Day, Year)

-08-200

**ORIGINAL** 

		•	1 - For State Registrar	State of	Marylar				lealth a Death	and M		giene Reg. No.	2007	7 01	533
			1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	ath Day	Year	3. Time o	f Death
	Physici /Medio		MARGERAM	120 Kins								٦	07	615	Дм
	Examin		4a. Facility Name (If not institution,	give street and numb	ber) (12	ויסמינכ	4b. City	, Town, or	Location	of Death		4c.	County of Dea	ath	
			DEEL HERD	2) Latigrel	ntage C	BER	50)	aria	URY	mp	MARINA	N	commes ?	County	
_	Funeral			6. Sex / 7		last birthday)	If Unde	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth av. Year)	9. Bi	rthplace (State	or Foreign
	Director		214-12-5893	1□M 20 F	86	Yrs.	WORKIS	Days	110013	IVIII.	9-9	-192	Ma	ryland	
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J	13°	- a	1702 Eastgate V					2180					USA		
-	ems	ne	11. Marital Status	12. Was Deced	ent Ever in U es?	J.S. 13.	Was Dece If Yes, spe	edent of H	ispanic Ori in, Mexicar	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Wh	nerican Indian, lite, etc.	
98	or li	y F.	1 Never Married 2 Marri	If Yes, Give			1 🗆 Yes	2 X No	Specify:				Specify:	White	
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7	72 I	ete	15. Decedent (Specify only highes			16a. Dece	dent's Usu	ork done	ation during mos f)	t of work	ing	160. Kir	nd of Busines	s/industry	
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	iled v tygie ther t		11 17. Father's Name (First, Middle, I	astl		Home	-marc		18. Mothe	ar's Nami	(First, Middle	Maiden			
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<u> </u>	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Man	T <sub>0</sub>	Eddie Lee Gosle			10h Mail	na Addena	o (Stroot)			I Route Numb			Zin Code)	
Maryland	od 2 st lith and 27 is r traur		19a. Informant's Name/Relationsh				•							MD 2183	7
	Tea Hea		Carolyn Adkins/ 20a. Method of Disposition	Daugitter	20b. F						Date			r Town, State	
10	Pages nent of H int: If Ite		1 XBurial 2 □ Cremation		IAIO	Ptace of Dispo cemetery, cre									
ţi	tmer tant dury		`4 □Donation 5 □Other (Sp	1 / 1	Sha	rptown								Maryla	nd
Baltimore,	permit. Pages. Department of I Important: If Ite any injury or of angles.		21. Signature of Funeral Service/L	Conson Sel	lec	$Z_{\epsilon}^{2}$	211er 212 0	Fune	eral cean	Home City	, P. 0. Road,	Box Sali	3171 sbury,	MD 218	02
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that can	used the deat	th. Do not en	ter the mo	de of dyin	g, such as	cardiac	or respiratory a	ırrest,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition	END	STAGE	Renal	1	13005	9					Onset and	Death
	/Medical		resulting in death)	- a.	r as a consec			13(14)							
	Examiner		Composinity list conditions	141thony	of (	Organtiv	5 1760	of to	SILVIE			_			
	P. =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consec		0		h						
	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. CHRON		structi	NG /1	rwon	Pry V	12001	?				
0	e exe ian a urial-i	Ex	resulting in death) Last	Due to (o	r as a consec	quence of):			(						
3760,	ate be ex nysician he burial	ical		d											
89	death certificate be execu e attending physician and of for use as the burial-trar	Med	IF FEMALE:												
Вох	th ce tendi	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome 1 Live bir	ome of pregnate the 2 Test		]Ectopic p	pregnancy				2	3d. Date of de Month	elivery Dav	Year
		sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregna 9☐Unknov	nt at time of o	death 5 [	Other (s	pecify)					WOITH	Day	1 041
P.0	at the	hy	9 Unknown												
	requires that the de een signed by the a nould be detached f	by [	Part II. Other significant conditio	ns contributing to dea	ath but not res	sulting in the t	anderlying	cause give	en in Part I	•			/	to the cause of	
ord	v requir been si should	ed	1/1patension								10	Yes 2	¥No 3 □ F	Probably 4	Unknown
S	~ Q 70	Completed									24a. Was		24b. Were a	autopsy findings completion of	available
æ	0 - 0	E										ormed?	death?		
ta	sicien: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Deat	n (Check only				
>		O B	examiner?	Hospital: 1 🗹 In	patient 2	ER/Outpatie	nt 3 D	OA Oth	er: 4 DNi	irsing Ho	me 5 Resi	idence 6	i □Other (Sp	ecify)	
0	g Phys er this eral di	n: T	27. Manyer of Death	28a. Date of	Injury Day Year)	28b. Time o	of	28c. Injun Wor	y at		28d. Describe	how injury	occurred		
ion	nding Fath. r: After e funer	atlo	1 Naturaf 5 ☐ Pending 2 ☐ Accident investig	4	, Day roar,	injury	М		Yes 2	No					
Division of Vital Records,	Attending ir death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	nod 200. Place	of Injury - At h	ome, farm, st	reet, facto	ry, office				(Street and		Rural Route Nur	nber,
Ö	al or afte I Dir	ert	4   Hollicide	Danami	g, etc. ( <i>Speci</i>	19)					Oily of 10	wii, Sialo)			
	Hospital 4 hours a Funeral tely filled	aic	29a. Certifier 1 Certifyin	g Physician: To the t	est of my kn	owledge, dea	th occurre	d at the tin	ne, date ar	nd place,	and due to the	cause(s)	and manner a	as stated.	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical (	Examiner: On the bas and manne		ation and/or in	ivestigatio	n, in my o	pinion, dea	ith occur	ed at the time,	date and	place, and du	ue to the cause(	S)
	To th Withir To th	Me	29b. Signature and title of certifier				29	c. Licens	e number			29d. Date	signed (Mor	nth, Day, Year)	
			Call (	Crisch.			T	0002	7527			1-8-	50		
			30:Name and address of person	who completed cause	of death (Ite	m 23a) (Type		,		,	0 :			]	
			1/211	mon mi	λ.	SHea	d Hos	pital	Cent	er	P.6 Box	2018	7, -A/15	bury MI	21802
	Sta	ite	31. Date filed (Month, Day, Year)	32. Re	gisty r's Sign	ature				7		-	,	-11	
	Regist		JAN	<b>0 9</b> 2007 ▶	Home	K	Sou	all 1							

State of Maryland / Department of Health and Mental Hygiene UU /

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Physic /Med Exam **Funeral** 

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heelih and Mental Hygiene.
Importent: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Examinar must be notified at ottes.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and cumpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	Registrar		Cer	rtificate of D	calli	F	Reg. No.	
ian	Decedent's Name (First, Middle, Las	•				2. Date of Dea	ath Day Year	3. Time of Death
ical	ROSA VIRGINIA AUS					JAN	6,2007	1 12,05 AM
ner	4a. Facility Name (If not institution, give		CT	4b. City, Town, or L	,	110	4c. County of De	
•	5. Social Security Number / 6. Se	hab + nyR	yrs. last birthday)		b U L X If Under 24 Hrs.	Ma.		mico.
	235-38-4574		33 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day APRIL 2	3,1923 WES	nthplace (State or Foreig Country) T VIRGINIA
	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Loc	cation				10d. Inside City Limits
৳	MARYLAND DORCHESTE		EAST NEV					1M Yes 2 □ No
ect	10e. Street and Number	710	EAST NEV	10f. Zip Code			10- 611	
Funeral Director	4 SOUTH MAIN STREE	ET		2163	L		10g. Citizen of What C USA	ountry?
Ine	11. Marital Status	<ol><li>Was Decedent Ever Armed Forces?</li></ol>	in U.S. 13. V	Was Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
by		1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	j	77	Specify:			WHITE
Completed	15. Decedent's Ed (Specify only highest grad		16a. Deced	tent's Usual Occupati	on		16b. Kind of Business	s/Industry
Jp.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. C	kind of work done du DO NOT use retired)	ing most or work	ng		
ő	11		HOMEM	AKER			OWN HON	ME
Be (	17. Father's Name (First, Middle, Last)			1	8. Mother's Name	(First, Middle,	Maiden Sumame)	
Tol	MORGAN LEROY SIX				MANORIA	JANE I	DEAN	
	19a. Informant's Name/Relationship (T	уре, Print)	19b. Mailin	g Address (Street an	d Number or Rura	l Route Numbe	r, City or Town, State,	Zip Code)
	T. LEE AUSTIN/SON		6319	SNUG HARBO	R ROAD,	EAST NE	EW MARKET N	ÆD 21631
	20a. Method of Disposition		0b. Place of Dispos			ate	20c. Location - City of	
	1 Daurial 2 Cremation 3 4 Donation 5 Other (Specify		-	NS CEMETER	y	2007 F	BEULAH, MAF	OVI AMD
	21. Signature of Funeral Service Licens		$\frac{1}{1}$	Name and Address	of Facility	P. O.	BOX 207	(ILAND
	1 Hendick	- ye	1	OO MAIN 21	KEEL, EA	IST NEW	MARKET MD	21631
	23a First Enter the disease, or comp smck, or heart failure. List only of	lic itions that cadsed the one cause of each line.	death. Do not ente	er the mode of dying,	such as cardiac o	r respiratory arr	est,	Approximate Interval Between
	Immediate Cause (Final disease or condition	· Mon	016	and e		Jul a	マン /	Onset and Death
	resulting in death)	Due to (or as a cor	nsequence (1):		7.1		Δ /	100
	Sequentially list conditions	b. Comp	= 1/ca	1	Hear	1 /a	elone	year
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or us a pr	rsequence of):	Δ		, ,	/	1
am	that initiated events resulting in death) Last	с.	men +	DUR	eoze			Year -
	resulting in death) cast	De to (or as a con	isequence o ):				-/	
Sa		d						
Aed								
	IC CCMALC.							
an/h	230. Was decedent pregnant	23c. If yes, outcome of pre		Ectonic pregnancy			23d. Date of de	livery
slclan/h		1□Live birth 2 □ l 4□Pregnant at time	Fetal death 3 1	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
hysician/k	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 🗍	Fetal death 3 1				i	,
by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1∏Live birth 2 ☐I 4☐Pregnant at time 9☐ Unknown	Fetal death 3 □ l of death 5 □	Other (specify)	in Part I.	23e. Did to	i	Day Year
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			Sta 1 - Stata Registrar	ate of Maryl		artmen ertificat			ınd Me		giene Reg. No.	007	015	35
	Physicia	an.	Decedent's Name (First, Middle, Last)							2. Date of Dea Month	Day	Year	3. Time of	
	/Medic		Woodward W		ahams,		Town or	Location of		Januar	-	, 2007 County of Death	12:00	) b w
	Examin	er	4a. Fecility Name (If not institution, give street Harford Memorial			4D. City,		re de		е	40.	Harf	ord	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthda		1 Year	If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Da	h V Year)	9. Birthp	lace (State o	or Foreign
	Director		218-03-9727 1XM	<sup>2□ F</sup> 89	Yrs.	Months	Days	Hours	IVIII.	Dec. 2	4,19	17 Ma	ryland	£
_	pue *		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or	Location						1	0d. Inside C	ity Limits
	Aaryle ( • ho	o	Maryland Cecil				t. Dei	posit					1 ☒ Yes	2 🗆 No
	the l	rect	10e. Street and Number	1		10f. Zip		•			10g. Citiz	zen of What Cour	itry?	
1	ith with the Marylen 23a or 28a-f show	ai D	41 South Main Street					2190	4			U.S.A.		
Z	within 72 hours after death with the Marylend ene. than "naturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 12. W	as Decedent Ever med Forces?	in U.S. 13	If Yes, spec	dent of Hi	spanic Orig	gin? (Spec , Puerto R	ify Yes or No- lican, etc.)	- 1	<ol> <li>Race - Americ Black, White,</li> </ol>		
36	s afte	y FL	If .	☐Yes 2⊠No Yes, Give ear or Dates:		1 🗆 Yes	2 <b>X</b> No	Specify:				Specify: W	hite	
$>>$ $\stackrel{\triangleright}{>}$	ture!	ed	15. Decedent's Education	Lacot to	16a. Dec	edent's Usua	al Occupa	ation				nd of Business/In		
7.	hin 72 In "ne Medit	plet	(Specify only highest grade con	pleted) ollege (1-4or 5+)	(Gir	e kind of wo DO NOT us	rk done a se retired,	during most )	of workin	g		. Postal		
CVE	THE R. LEWIS CO., LANSING, MICH.	Con	Twelve Years			Post	mast					t Deposi	t, Mar	ryland
and	t be filed ntai Hyg ed othe	Be	17. Father's Name (First, Middle, Last)	nd Wilson	Abaaba			18. Mothe		(First, Middle, artha (				
	D 9 2 0	ပ္	19a. Informant's Name/Relationship (Type, F	rd Wilson				and Numbe				r Town, State, Zip	Code)	
Mary	1772		Woodward Wilson Abra			-						ryland		
بَ فَ	-I ==		20a. Method of Disposition		b. Place of Dis	position (Nar rematory or o	ne of other place	a)	Da	ate	20c. Loc	cation - City or To	wn, State	
O E	Pages ent of I nt: If it		1 Durial 2 Cremation 3 Removed the Property of the Property o	al from State	Hopewel	-			01/10	0/07	Port	Deposit	, Mar	yland
/ - (	permit. Page Department: Important: It any injury o		21. Signature of Funeral Service Licensee	ENDON OF	< 1		Pati	tersoi	n & S	Son Fun		Home, E	.A.	
			23a. Part1. Enter the disease, or complicatio shock, or heart failure. List only one ca	ns that caused the	death. Do not e	inter the mod	le of dying	g, such as	cardiac or	respiratory ai	rrest,		Approximation of the Approxima	te tween
	Physician		Immediate Cause (Final disease or condition	Anten	25cles	otic	Cl	ardio	UTH	wlas	- 0	lisease	Oriset and	Deali
CHON	/Medical Examiner		resulting in death)	Due to (or as a cor	sequence of):	1		1	1					
1900	*	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or s a cor	ns uence of):	ar_	ou	16/6/	ихі					
	be executed sicien and burial-transit	Examiner	that initiated events C.	Cordon	car	Chyl	MIL	V.						
90.	De exe		resulting in death) Last	Due to (or as a cor	nsequence of):	V.								
928	physic physic s the b	dicai	d.									1		
Box 68760.	eath certific ettending p for use as	Physician/Med	IF FEMALE: 23c. If	yes, outcome of pr □Live birth 2 □		. — — — — — — — — — — — — — — — — — — —					2	23d. Date of delive	ary	
	ne death the ette hed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	☐Pregnant at time ☐Unknown		3 □Ectopic p 5 □ Other (s <sub>t</sub>						Month	Day	Year
, 0	that the de ed by the detached	Phys	9 Unknown		t consulting in the	. undarhina i		on in Part I		23a Did t	obacco u	se contribute to t	he cause of	death?
John St.	w requires that been signed should be de	٥	Part II. Other significant conditions contribu	ang to death but no	t resulting in the	r underlying t	ause give	eri ili Faili.		1	Yes 2[	1 /		]Unknown
	2 a a	Completed								24a. Was autor perfo		death?	opsy findings impletion of a	available cause of
A let		BeC	25. Was case referred to medical examiner?	. /				26. Place	of Death	Check only o	one)	+		
8 5	Physician: this certific ral director,	5	1 ☐ Yes 2 ☐ No Hospi	1 Minpatient	2 ER/Outpat			4 🗀 Nu				6 ☐Other (Special	<i>y</i> )	
1		io	1 Sometard 5 Training	ta. Date of Injury (Month, Day Yea	28b. Time ar) Injur	M I	28c. Injun Worl	yat k? Yes 2.⊟l	1	8d. Describe	now injury	y occurred		
) Division	Attend er death rector: by the f	Certification:	3 Suicide 6 Could not be	e. Place of Injury -						8f. Location (	Street and	d Number or Run	al Route Nur	nber,
ig	s efter	Certi	4 Homicide	building, etc. (S	pecify)					City or To	wn, State,	,		
	To the Hospital or Attending within 24 hours eller death 25 to 10	edicai (	29a. Certifier (Check only one) Certifying Physicia 2 Medical Examiner:											(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	/ A	m	29	c. Licens	e number	111		29d. Dat	e signed (Month,	Day, Year)	
	, com		1 / Lu	///	1/			TOX	56 (		(	101		
	8		30. Name and hidress of person who comple	ted cause of death	(Item 23a) (Typ	Vivision	115	1-10	taur	rodoc	201	200 11	1021	DZR
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	2 010	7)	1 . 1		204	-110	a for	V - 0	- 0
	Regist		IAN 1: 0 2007	Contract to	1 does	le								

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			1 For State	State of Maryla	nd / Depa	artment of	Health and	Mental Hygie	•	01506
			1 State Registrar  1. Decedent's Name (First, Middle, Last	1	Cei	tificate o	t Death		Not UU /	01000
п	Physic	an						Date of Death     Month	Day Year	
1	/Medi Examir		Daniel W.  4a. Facility Name (If not institution, give			4h City Town	, or Location of Dea	January	3 2007 4c. County of Dea	
	LAdillia	IEI	918 Booker Driv				Capitol H			
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	. last birthday)	If Under 1 Yea	ır if Under 24 Hı	s. 8. Date of Birth		George's  rthplace (State or Foreign
	Director		238-34-6793	XM 2□F 8	Yrs.	Months Day	s Hours Mi	May 15,		th Carolina
	pue *		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	oation				
	Aaryli f aho	ō			ity, TOWIT OF EQ	Callori				10d. Inside City Limits 1 XYes 2 No
	28a-	Director	Maryland Prince 10e. Street and Number	George's		10f. Zip Code	Capitol		Civi4 1481 0	
	3a or	ā	918 Book	ow Dwizzo		Tot. Zip Code		100	. Citizen of What C	_
	ms 2	by Funerai	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of	20743 Hispanic Origin? (	Specify Yes or No- into Rican, etc.)	14. Race - Am	States erican Indian.
ထ္	after or its	Fu	1 Never Married 2 Married	Armed Forces? 1 □XYes 2 □ No If Yes, Give				nto Rican, etc.)	Black, Whi	te, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f ahow ta Madical Exartirar must be rodified at	d b	3 ☐Widowed 4 ☐ Divorced	Year or Dates:		☐ Yes 21XN	o Specify:		Specify:	Black
<u>7</u>	nati	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	(Give	ent's Usual Occi kind of work don	e durina most of w	orking 16	b. Kind of Business	/Industry
12	within ene.	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retir				
<u>0</u>	Hygi Other		17. Father's Name (First, Middle, Last)		1 1	<u>lachinis</u>	t Superv	ISOT ame (First, Middle, Ma		overnment
au	ic av	To Be	Dance Anth	onv				Rowan		
Maryland	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other than "natural", or itams 23e or 28e-f ahow any injury or other treumatic avant, the Madical Examinat must be notified at once.		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Stree	et and Number or F	Rural Route Number, C		Zip Code)
Σ	and 2 salth n 27 t		Larry Anthony, S	r./Son	14	4629 Alm	nanac Dr.	Burtonsv	ille. MD	20866
ore	of He		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ F	20b. F	Place of Dispos cemetery, cren	sition (Name of latory or other pl	ace)	Burtonsv Date 20	c. Location - City or	Town, State
altimore,	Peg ment ant: i		4 Donation 5 Other (Specify)				Park 1/1	0/2007	Landove	r, MD
Ball	epart nport ny In		21. Signature of Funeral Service Licens		22	Name and Add	ress of Facility	Stewart Fu	neral Hom	e
	40 F 4 0		10hw 1, 2	leval, III		4001	Benning 1	Rd., NE Wa	ash., DC	20019
			23a. Part1. Enter the disease, or complished, or heart failure. List only or	ie cause on each line.				-		Approximate Interval Between
E	Pnysician /Medical	9	Immediate a use (Final disease or ond ition resulting in death)	Continosa	leroh	e Card	hoverent	lar disea	se	Onset and Death
	Examiner			Due to (or as a conseq	juence of):	1200	0 7 0			
	, N	e e	Sequentially list conditions, if any, leading to immediate	Due to (or as a o nseq		Rena	e biseo	vie .		
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Huserte.	nain	`				
o o	te be executed ysicien end te burial-transit		resulting in death) Last	Due to pres a conseq	uence of):					
	a ≥ e	cal								
9	death certifica e attending ph d for use as tt	Med	IF FEMALE:	10000	***	-	780			
Box	leath certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	зу		23d. Date of del	
	at the de by the a stached f	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5 🗆	Other (specify)			Month	Day Year
J.	= <b>0</b> ∪	Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	deriving cause g	van in Part I	23a Did tohac	oo uso contributo te	the cause of death?
Records,	86 15 6	Ω		•		oony mg oddoo g	TOTAL CALL	1 ☐ Yes		obably 4 @Unknown
Ö	w require been signature should b	Completed						-		1
P T	0 - 2 0							24a. Was an autopsy performed	prior to o	topsy findings available completion of cause of
	certificate	ပိ	25. Was case referred to medical					1 ☐ Yes 2 🗷		2 No
5 ∶	Physician: this certific ral director,	To B	examiner?	ospital:	ER/Outpatient	3□ DOA Ot		ath <i>Check</i> only one Home 5 ∰ Residence	6 DOM: (C	-16.1
ָם פֿר	ding Phys h. After this funeral dir		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju	ry at	28d. Describe how i		ciry)
NISION	andir sath. or: Af he fu	ätic	1 Natural 5 Pending 2 Accident investigation	(Wellin, Day 1 dai)	Injury		ork? ]Yes 2∐No	!		
Ĕ	iractor by t	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (Street City or Town, St	t and Number or Ru	ral Route Number,
ָ ב	urs ef									
	io the hospitel or Attanding Property of the Funeral Director: After the Completely filled in by the funeral	edicai	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examin	ician: To the hest of my knower: On the basis of examinal	wheelge, death tion and/or inve	occurred at the traction, in my	ims, date and place opinion, death occu	or and due to the eaust	and place, and due	stated. to the cause(s)
3	ithin mple		29b. Signature and title of certifier	and manner stated.		29c. Licen			Date signed (Month	
,	(H)		Dislib To	Associ C	270	3	41945		01/09/0	
	6		30. Name and address of person who cor	mpleted use of death (Item	23a) (Type. P	rint)			0.70770	/
	SC.		CIELITO AGUI	NALDO MO	1221	MERCA	ntile i	-AME LA	RGO MI	20723
	Stat	<b>-</b>	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture					
	Registra	L C	IAN 1 0 2007 Z	A Andre	K)					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** RAFAEL EMILIO ARIAS January 5, 2007 10:37 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign
Country) **Funeral** Months Days 1**X** M 2□ F Yrs. 3-29-1941 Director 213-39-7615 65 Dominican Republic Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or iteme 23a or 28e-f ehow ury or other traumatic event, ite Medical Examinar must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Director Maryland | Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 53rd Place, 3908 #202 20784 Dominican Republic Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1X Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Dominican Hispanic Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Shoemaker Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Silvio Arias Maria E. Tejeda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Altagracia Arias - Wife 3908 53rd Place, #202, Hyattsville, Maryland 20784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □Cremation 3 NRemoval from State San Jose de Ocoa Dominican Republic permit. Page Depertment of Important: if any injury or once. ¦1/14/2007 4 □ Donation 5 □ Other (Specify) Arias Family Mausoleum 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Claudatte Dasch Janning Gasch's Funeral Home, P.A.

23a. Part1. Enter the disease, or complications that caused the death. Bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hyattsville, MD 20781 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai Examiner physicien and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 use as the ettending properties of the second se IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown cete hes been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 Yes 2 No 3 Probably 4 □Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 Yes 2. No 2 🗌 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 24 hours efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical pletely t 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) COU 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5711 SARWS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

ORIGINAL

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Registrar

			1 - For State Registrar	State of	Marylan		artmen rtificate				lental Hy	giene	$\sim$ 1111	7	01	539
П	Physici	an	Decedent's Name (First, Middle, L.	ast)							2. Date of Dea	Day	, Y	ear	3. Time o	
	/Medic	al		NG AMSEL							Januar	-			11.00	MAC
	Examin	er	4a. Facility Name (If not institution, gi RENAISSANCE GARD)			T	4b. City,		Location of		TNC	4c.			COMEDI	.,
	Funeral				. Age (In yrs.		If Under		LVEK If Under	24 Hrs.		h				
	Director		052-14-1995	1 <b>I</b> SM 2□F	88		Months	Days	Hours	Min.	8. Date of Birt (Month, Da) DEC 18	, Year) 19	18	What Coun  USA ce - Americality (by: Will  usiness/Ind  CIAL/: ne)  State, Zip 931: - City or Tou ARYLAN  LS, IN  ARYLAN  were autoported to com death? or (Specify) and due to to did (Month, D  and did to to did (Month, D  ARYLAN  ARYLAN  er (Specify) and did to to did (Month, D  ARYLAN  ARYLA	NY	or r or orgri
	p ,		Usual Residence of Decedent  10a. State 10b. County		10- 0:-	y. Town or Lo										
	ahov	7			ioc. City	y, lown or Lo								11	0d. Inside C	ity Limits 2 □ No
	28a-f	Directo	MARYLAND MONTGO	OMERY			SI 10f. Zip		SPR	ING		10- 04	140-	10		20110
	With be or	2	3160 GRACEFIELD H	ROAD			TOT. ZIP	Code	2090	06		rog. Citiz			itry r	
	ms 2;	Funerai	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13. V	Was Deced	lent of Hi			ecify Yes or No- Rican, etc.)	. 1			an Indian,	
9	or Ita	Fu	1 ☐ Never Married 2 ☐ Married	Armed Force	. Xi No	1					Rican, etc.)					
003	72 hours after death with the Maryland Institute!, or Itams 23a or 28e-f show dical Essolicat court be ricitified at	d by	3X Widowed 4 □ Divorced	If Yes, Give Year or Date	es:		1 ☐ Yes 2	ZALI NO	Specify:				Specify:	W	HITE	
15	natu	Completed	15. Decedent's E (Specify only highest gi			(Give	dent's Usua kind of wor DO NOT us	rk done d	uring mos	t of work	ing	16b. Kir	nd of Busin	ness/ind	dustry	
12	filed within Hygiene. other than "	dmo	Elementary/Secondary (0-12)	College (1-4		<i>me. t</i>	STOC					ידים	MANCT	ΛТ /:	TNVECT	ייא ביאיתי
D	Hyg other	Be C	17. Father's Name (First, Middle, Las				_5100	ICDICO		er's Name	e (First, Middle,			ΑЬ/.	TMAESI	LMENT
Maryland 21215-0036	should be nd Mental marked c	To B	ALBERT B. AMSEL								Y LEVINS					
Mar	alith a		19a. Informant's Name/Relationship RICHARD AMSEL/SON								al Route Numbe TA BARBA					
re,	es 1 ar of Hea f item r othe		20a. Method of Disposition			lace of Dispo emetery, cren	sition (Nam	ne of	Į.		Date					
E	Pages nent of I int: If it		¹X☐ Burial 2 ☐ Cremation 3 [  '4 ☐ Donation 5 ☐ Other (Speci		are	EAN ME		-		01/1	5/2007 A	DELI	PHI,	MARY	YLAND	
Baltimore,	permit. Pag Department Important: any injury o	20a. Method of Disposition  Commettery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)  3 Commettery, crematory or other place)  4 Donation 5 Other (Specify)  21. Signature or Funeral Service Licensee  22. Name and Address of Facility, DANZANSKY—GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MARYL									. II	NC.	0852			
4			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cau	used the death	. Do not ente	er the mode	of dying	, such as	cardiac (	or respiratory an	est,	, min	100	Approximat Interval Bet	e
	Physician		Immediate Cause (Final disease or condition	. Athe	YOSC	lerot	ic C	ard	iova	Scu	lar d	Ska	Se		Onset and	
	/Medical Examiner		resulting in death)		as a consequ	uence of):										
		16	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to for	as a consequ		dy Cu	101	na					_		
	nsit	m In	Cause (Disease or injury	D <b>40</b> 10 (01	43 4 0013640	dilog (i).										
o.	exection and and ital-tra	Examiner	that initiated events resulting in death) Last	Due to (or	as a consequ	ience of):										
8760,	icate be executed physician and s the burial-transit	dicai	(	d												
39 x	e as t	0	IF FEMALE:													
Вох	leath certifical attending place as t	lan/	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Fetal	death 3	Ectopic pre					2:	3d. Date of Month		,	Year
P.O.	that the de ed by the a detached t	Physician/M	1 Yes 2 No 9 Unknown	4∐Pregnan 9☐Unknow	nt at time of de m	eath 5∐	Other (spe	ecify)					1011111		Juy	i oui
۳.	res that igned by be deta	by Ph	Part II. Other significant conditions	contributing to deal	th but not resu	ilting in the un	nderlying ca	use give	n in Part I.		23e. Did to	bacco us	e contribu	te to the	e cause of d	leath?
Division of Vital Records,	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as t										1 🗆 Y	es 2□	]No 3[	] Proba	ibly 4 d	/ Jnknown
000	has bei	Completed									24a. Was a		24b. Wer	e autop	sy findings	available
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10	Physi this al dir	٦.	1 Yes 2 No	Hospital: 1 ☐ Inp 28a. Date of I		R/Outpatient		-	4 NUI		me 5 🗆 Reside			Specify)	)	
O	ding I	tlon	1. ✓ Natural 5 Pending 2 Accident investigatio	(Month,	Day Year)	28b. Time of Injury	M 28	Bc. Injury Work	at es 2 □ N		28d. Describe ho	ow injury	occurred			
/IS	l or Attending Physician: after death. Director: After this cartification by the funeral director.	ifica	3 Suicide 6 Could not b	e 28e. Place of	Injury - At hor	me, farm, stre					28f. Location (St	reet and	Number o	r Rurai	Route Num	ber.
á	s after solution of in the	Certification:	4 Homicide determined	building	, etc. (Specify,	)	,				City or Town	n, State)				
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	omple	Med	29b. Signature and title of certifier	and manner	Siated.		29c.	License	number		2					
	->-0		Loveen	Kuhun	rang	MD		DE	595	24						07
	17		30. Name and address of person who LOVEEN J. PUT L	completed cover	-4 -1ab (1a	20-) (T [	7-1-41									
40.	Sta	e	31. Date filed (Month, Day, Year)  JAN 08 20	32 <b>.</b> eg	istrar's Signati	ure		_ ~	0011	,,,	,			)	1 20	10-7
	Registra	ar	JAN 08 20	101	istrar's Signati	K AS	May 1									

07-00004 Print in Black Indelible Ink. Ensure All Copies Are Legible. Please Type Precious Alton Maryland / Department of Health and Mer 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle Last) Physician/ 2. Date of Death Time of Death Medical Examiner Month Precious Toni Lee Alton 0147 hrs January 1, 2007 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Dry Run Rd north of Blackhawk School Rd Swanton Garrett 5. Social Security Number UNK **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Davs Hours Director 11 Dec. 20, 1995 Country)Maryland M 2XX Yrs Usual Residence of Decedent IBY 10c. City. Town or Location 10d. Inside City Limits Maryland Garrett or 28a-f show Swanton 1 Yes 2 X No nours after death with the Maryland 10e. Street and Number at 10f. Zip Code 10g. Citizen of What Country 104 Misty Mountain Road 21561 U.S.A. or items 23a Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Married Yes 2 X No Widowed f Yes, Give Year Divorced Yes 2 X No specify "natural", Specify White Examine \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. If item 27 is marked other than "na ner traumatic event, the Medical Ex during most of working life DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John Dale Carden Georgina M. Alton æ ၀ 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalie Alton/grandmother 819 Bradford Avenue Arnold, Maryland If item 27 20a Method of Disposition 20b Place of Disposition (Name of cemetery or other crematory or other place) 1 X Burial 2 Cremation 3 Pages 1 Removal from State Department of Important: Hillcrest Mem. Gardens 1/8/2007 Annapolis, Maryland Donation 5 Other Specify 22. Name and Address of Facility Jo M. Tay or Funera Home 21. Sign of Fu lera Service Lieensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and Death /Medical a Multiple Injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Sa physician a UNPENDED AMENDED Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown Unknown signed by the be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✔ Yes 2 ✓ Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26 Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ✓ Yes After 1 27. Manner of Death 28a. Date of Injury (Month Day Year) Jan 1, 2007 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Passenger auto fixed object collision 0100 hrs 5 Pending Yes 2 V No within 24 hours after death.

To the Funeral Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Dry Run Rd north Blackhawk School Rd, Swanton, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 2 🗸 and manner stated 29b Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. January 2, 2007 el 3 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year)

State Registrar

ignature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Alfredo Κ. Aviles 12:07 p<sup>M</sup> January 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Rockville Montgomery Shady Grove Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 1 X M 2 □ F Days 77 10-16-1929 Bolivia Usual Residence of Decedent

10f. Zip Code

1X Yes 2□ No

16a. Decedent's Usual Occupation

Pastor

22515

(Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify: Bolivian

18. Mother's Name (First, Middle, Maiden Surname)

10d. Inside City Limits

10g. Citizen of What Country?

14. Race - American Indian,

White

Bolivia

Specify:

16b. Kind of Business/Industry

Church

Rockville, Maryland, 20852

1X Yes 2 □ No

10c. City, Town or Location

College (1-4or 5+) 5+

Clarksburg

death with the Maryland ral", or Items 23a or 28a-f show Examiner must be notified at Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exa

Physician

/Medical

Examiner

none

10e. Street and Number

11 Marital Status

10b. County

22515 Schoolfield Court

Ajit P. Kuruvilla, MD

15. Decedent's Education (Specify only highest grade completed)

Maryland Montgomery

1 ☐ Never Married 2 ☐ Married

3 X Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

10a. State

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

**Physician** /Medical Examiner

To the Hospital or AttendIng Physiclan: The law requires that the death certificate be executed within 24 hours after To the Funeral Discompletely filled in

Division or Vital Records, P.O. Box 68760,

To B	unknown			Deidami	a Aviles		
_	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailing Addres	s (Street and Number or F	Rural Route Number, City	or Town, State,	Zip Code)
	Victor Aviles/son		Clarksbu	rg, Maryland	, 22515		
	20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Re	emoval from State	ace of Disposition (Na emetery, crematory or	4		Location - City or	
	4 ☐ Donation 5 ☐ Other (Specify)	Che		rematory 01-		_	
	21. Signature of Funeral Service License	Bacon CC3		and Address of Facility $oldsymbol{W}$ . 14th Street,			
	23a. Part1. Enter the disease, or complete shock, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not enter the mo	ode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)		al Failure				1 day
	resulting in death)	Due to (or as a consequ	ence of):				
	Sequentially list conditions	Hepatorenal					1 day
Je.	Sequentially list conditions, cause. Enter Underlying	Due to or as a conse	ience of :				
Ē	that initiated events						
ŭ	resulting in death) Last	Due to (or as a consequ	ience of):				
-g	d						
Physician/Medical Examiner							
1	IF FEMALE: 23b. Was decedent pregnant	3c. If <u>yes,</u> outcome pf <u>preg</u> na				23d. Date of de	elivery
cia.	in the past 12 months?	1□Live birth 2□Fetal				Month	Day Year
ysi	1 □ Yes 2 🔯 No 9 □ Unknown	9□Unknown					
듄	Part II. Other significant conditions con	tributing to death but not resu	Ilting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
d by					1 ☐ Yes	2[ <b>X</b> No 3□ P	robably 4 □Unknown
Completed					24a. Was an	24b. Were a	utopsy findings available completion of cause of
崩					autopsy performed	?   death?	
ပိ	OS Was one referred to modical				1  Yes 2 1 1	No 1 □ Ye	s 2X No
Be	25. Was case referred to medical examiner?	ospital: 4 X leastiont 2 🗆			eath (Check only one)		
P	1 1es 2 <b>A</b> 140	1 Zympatient 2 🗆	ER/Outpatient 3	OOA   Wursing	Home 5 ☐ Residence	6 ☐Other (Spe	ecify)
ation:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Medical Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, street, facto	ory, office	28f. Location (Street City or Town, Sta	and Number or F ate)	Rural Route Number,
ial Ce		sician: To the best of my kno ner: On the basis of examina					
edic	one)	and manner stated.	non and/or investigation	on, in my opinion, death oc	curred at the time, date a	and place, and du	e to the cause(s)
Ž	29b. Signature and title of certifier	2	2	9c. License number	29d. [	Date signed (Mon	th, Day, Year)
	1 mus	AJI P.KUR	JULLA, WI	D46187	Jan	uary 3,	2007
	30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)				

State Registrar 32. Registrar's Signature

11125 Rockville Pike Suite 208

			For State Registrar	State	e of Marylai		artmen				-	- 9	007	0154	2
Ç.	No.	<u>ķ</u>	Decedent's Name (First, Middle	e, Last)							2. Date of De Month	ath		3. Time of De	ath
	Physici /Medic		Albert	Ε.		rvin					January		2007	10:45	$A^{M}$
	Examin	er	4a. Facility Name (If not institution		d number)				Location of	of Death		And Day Year 7 2007  4c. County of Death Frederick Prederick Prede			
N.	` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `		2634 B Lander 5. Social Security Number	Road 6. Sex	7. Age (In yrs.	last hirthday)	Jei i If Under	erso	On If Under	24 Hrs.	8 Date of Rin	th		CICK Birthplace (State or Fo	roian
- 16 18.0	Funeral Director		216-14-6449	1⊠M 2□		Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Iulv 20	y, Year)		Country)	iraigi i
	pu ,		Usual Residence of Decedent											-,	
	ed at	'n	10a. State 10b. County		10c. C	ity, Town or Lo								10d. Inside City L	
	28e-f	rect	Maryland Fred  10e. Street and Number	erick		Jeff	erson 10f. Zip	Code			———Т	10g Citi	zeл of What i		
	3a or	Funeral Directo	2634 B Lander	Road			10		755					•	
	death	ner	11. Marital Status	12. Was	Decedent Ever in telegraphics of the Decedent Ever in the Decedent Ever	J.S. 13.	Was Deced			gin? (Spec	offy Yes or No lican, etc.)	-	14. Race - Ar	merican Indian,	
98	or ite	by Fu	1 Never Married 2 Marr	ied 1 🗆 Y	es 2 X No Give		1 ☐ Yes 2		Specify:		iicari, eic.			White	
Ö	72 hours after death with the Maryland natural', or items 23s or 28e-f ehow dissil Examinational be notified at	q pa	3 Widowed 4 Divorced		or Dates:	16a Daca	dent's Usua	I Ossus	tion			165 V		20/Industry	
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212	e filed within al Hygiene. I other than "	mo:	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+)	1	Welde:	r				C	Constru	stion	
nd	be filed tal Hygid d other	Be	17. Father's Name (First, Middle,						18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)		
Z	2 should be and Mental Is marked o	10	Albert Arvi			101 11		10:			May I				
Maryland 21215-0036	d 2		19a. Informant's Name/Relations Mary S. Arvin				ng Address B Lat					-		191	
re,	s 1 and 3 f Health item 27 othar tr		20a. Method of Disposition			Place of Dispo	sition (Nan	ne of	,	Da	ite				
E O	Page: nent o nt; if		1			cemetery, crei • Pau1				anuar 200	y 10,	Jeff	erson	Maruland	
Baltimore,	permit. Pages 1 an Department of Heal Important; if item 2 any injury or other once.		21. Signature of Fundral Strvice	Licensee/		22	2. Name an	d Addres	s of Facilit		-				
	90 E 2 9			10			100 N			venue	Brur	swic	k, Mar	yland 217	16
			23a. Part1. Enter the disease or shock, or heart failure. List	complications the only one cause	hat caused the dea on each line.	th. Do not ent	er the mode	e of dying	, such as	cardiac or	respiratory ai	rrest,		Approximate Interval Betwee Onset and Dea	
M	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		ALL (	ELL	L	UNG	CAT	VCER	•		20 mon	
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46	e e	Jer	Sequentially list randitions if any, leading to immediate	b. Due	e to (or as a conse	quence of):									
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.											
Ö,	ate be executed thysician and the burial-transit		resulting in death) Last	Due	e to (or as a conse	quence of):									
8760,	cate b	dicai		d.											
Box 6	that the death certificed by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes	, outcome of pregn	ancy							23d Date of d	olivon	
	death e atter d for r	iciai	in the past 12 months? 1 □ Yes 2 □ No	4□P	ive birth 2 🗆 Feta regnant at time of o		Ectopic pro Other (spe					•			r
P.0	by the	hys	9 Unknown	91.10	Inknown										
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000	aw requir as been si 2 should	Completed									24a. Was		24b. Were	autopsy findings ava	lable
	The lay ate has page 2	mo									autop perfo 1 Yes	rmed?	death?		9 Of
/ita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Harrist						of Death	Check only o	ne			
of	<b>ਦ</b> ≑ ਭ ∣	-T	1 Yes 2 No	_		ER/Outpatier 28b. Time of			4 🗀 140					pecify)	
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Division of Vital	Attar ar dea actor by the	Certification:	3 Suicide 6 Could a	ned 208. P	lace of Injury - At h	ome, farm, str	eet, factory	, office		28	of Location (S	Street and	Number or i	Rural Route Number,	
ā	rs afters el Dire	Cert	4		unding, etc. (Speci	·y/					City of You	vii, State)	'		
	To the Hospital or Attanding within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 ☐ Certifyin (Check only one)  1 ☐ Certifyin 2 ☐ Medical	Exeminer: On th	o the best of my knone basis of examination manner stated.	owledge, death ation and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, ar th occurred	d due to the	cause(s) date and	and manner and di	as stated. ue to the cause(s)	
	To ti To ti comp	Σ	29b. Signature and title of certifier		MD			License							
}			P Com.					000	5631	4		J-KW V	W/ O/	2007	
2			30. Name and address of person	who completed (	cause of death (Item	m 23a) (Type, THOMAS	Print) JOHN	190N	DRIV	E FR	EDERICK	- n	ND 2170	2	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 0	<b>9</b> 2007	2. Reffistrar's Sign	ature A	parti	P							

				Pleas	е Туре с										-	le.		
			for State		State	of Ma	arylan					nd Me	ental Hy	/giene	9			1 0
			Registrar  1. Decedent's Nam	e (First Middle	(ast)			Ce	runca	le or i	Deam		2 Date of D		200	)7	1 3 Time	of Death
	Physicia		BOBBY	•		LGER							Month	Da			6:10	P M
)	/Medic Examin		4a. Facility Name (/		-			-				Death			-		1	
3.4	`` <u>-</u>		5. Social Security N	RICK MEM	ORIAL H			last birthday		EDERI er 1 Year		January 7 2007  cation of Death  K  Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 17, 1926  Dot. 17, 1926  Jusa  Jusa				te or Foreign		
	Funeral Director		236-28-		1 <b>X</b> M 2□	F	80	Yrs.	Months			Min.	(Month, D	ay, Year)	'	Col	t Vir	
pages.	w		Usual Residence of	Decedent 10b. County			10c. Cit	y, Town or L	ocation			- 15		,				City Limits
	Maryla -f sho ied at	tor	WV	Jeffer	son -			rpers		V								es 2X No
	th the or 28a e notifi	)irec	10e. Street and Nu					- POLO		p Code				10g. Cit	tizen of Wi	hat Cou	untry?	
	s 23a o	ral		irang Wa			<u>- 1</u>	0 40			425	0.40					ises Indian	p. 1
_	fter de r Items Ilner n	Funeral Director	<ol> <li>Maritai Status</li> <li>Never Marr</li> </ol>	ried 2∐ Mamie	d 1X1Y	d Forces? es 2∐1		5. [13.				Puerto R	ity Yes or N ican, etc.)	10-				
2-003p	be filed within 72 hours after death with the Maryland tal Hygiene. An other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	3 ₩ Widowed	4 Divorced	If Yes, Year o	, Give or Dates:	L945 <b>-</b>		1 🗆 Yes								nite	
ב	n 72 h "natu edical	Completed		15. Decedent's cify only highest	grade complete			16a. Dece (Giv	edent's Usi e kind of w DO NOT i	ual Occup ork done use retired	ation during most o	of working	7	16b. K	ind of Bus	iness/l	ndustry	
7	d withi giene. er than the M	omp	Elementary/Seco	ondary (0-12)	Colleg	ge (1-4or 5	5+) 		ineer					U.	S. G	ove	rnmen	t
B	be file ital Hy d othe event,	Be	17. Father's Name		,										Surname	)		
ryia	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparkment of Health and Mental Hygiene. Deparkment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or thems 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	그	Manue1	L. Alge				19h. Mail	lina Addres	s (Street					or Town S	State 7	in Code)	
<u> </u>	alth an 27 ls or trau		Patricia				er		_									
ည် စ	of He		20a. Method of Dis				20b. P	lace of Disp emetery, cre	osition (Na ematory or	me of other plac	ce)	Da	te	20c. L	ocation - C	city or	Town, State	
baltimor	t. Pag rtment rtant: I		4 Donation	5 Other (Sp	ecify)		Bro											
מ	permi Depar Impor any ir		21. Signature of F	uneral Service L	Some		M	070				Lac		4-	Year 2007 County of Death REDERICK 9.8 Birth Co. 926 Wes  Ves  Ves Ves Ves Ves Ves Ves Ves Ves	rton	Funeral	
31			23a. Part1. Enter to shock, or hea	the disease, or cart failure. List o	complications the	nat caused	the death	n. Do not er	nter the mo	de of dyir	ng, such as ca	ardiac or	respiratory	arrest,			Approxin	nate 3etween
	Physician		Immediate Cause disease or condition resulting in death)	(Final				cel	1 /1	w	19	200	cer	-			Onset ar	11
,	/Medical Examiner		resulting in death)	1	Due	to (or as	a consequ	uence of):			2							
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100	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IE EELAAL E	-	d													
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ν, T	ss that gned b	by Pł	Part II. Other signi	ificant condition	ns contributing t	to death b	ut not resi	ulting in the	underlying	cause giv	en in Part I.		23e. Did	tobacco	use contrib	oute to	the cause of	of death?
ecords	requir													<b>-</b>	□ No (	3 🗌 Pro	obably 4	Unknown
e L	The law ate has b	Completed												s an opsy formed?	pr	ior to c	topsy finding ompletion o	as available cause of
	an: T rtificate tor, pa	a	25. Was case refe	rred to medical							26. Place o	of Death (	1□ Yes Check only		1[	□Yes	2□ No	
O	Physician: r this certific ral director,	To B		X40		npatie		ER/Outpatie			4 □ Nurs						ify)	
SIOU	ding P h. After funera	tion:	27. Manner of Dea 1X Natural 2 Accident	th 5 Pending investiga	(1	ate of Inju Month, Dag	y Year)	28b. Time injury	of M	28c. Injur Wor 1 □	ryat k? Yes 2∐No		d. Describe	how inju	ry occurre	d		
	Attending or death.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	ot be 28e. P	lace of inju	ury - At ho	ome, farm, s	treet, facto				f. Location	(Street ar	nd Number	r or Ru	ral Route N	umber,
5	ital or urs afte iral Dir																	
	To the Hospital or Attending Physician. The law requires that the death certificate by within 24 but outs after death. Within 24 but outs after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but out of the completely filled in by the funeral director, page 2 should be detached for use as the but of the completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)	1 Medical E	xaminer: On th	the best he basis o nanner sta	f examina	wiedge, dea tion and/or i	ath occurre investigation	d at the tir on, in my c	me, date and opinion, death	l place, ar h occurre	nd due to the d at the time	e cause(s e, date an	) and man d place, a	ner as nd due	stated. to the caus	e(s)
	To the within То the сощр!	Me	29b. Signature and	d title of certifier		٨			29		e number			29d. Da	te signed	(Month	n, Day, Year	)
	. n		· Ca	uli Je	Sesser	Utm	n			wg	0268	890			8/2	00	7	
27	1/1/4		30. Name and add	ress of person w	ho completed o	cause of d	eath (Item	1	, Print)	ath	A	00:0	7	-1100	Wick		and:	21716
#.	Sta		31. Date filed (Mor	nth, Day, Year)	9 2007 <sup>3</sup>	2. Relistr	ar's Signa	ture	1	0		EILOR	- 12,	(UII)	will.	- (	V VI O	e no
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 544 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** AKHMEDOVA BATUN 200 0:000 ANUARY /Medical 4a. Facility Name (If not institution, give street and number) Examiner LOUNTY HOSPITAL WASHINGTON AGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1□M 2 7 F Hours GEORGIA 220-71-2251 70 Director JAN. 2, 1937 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at WASHINGTON Md. HAGERSTOWN 1 ☑Yes 2 ☐ No **Funeral Director** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ELIOT Dr. GEORGIA LITTLE 12801 21743 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: ISLAMIC Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) FAMILY the HOUSE WIFE other 1 Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Akmedov UNENOWN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12801 Little David tector DR. HAGBRSTOWN MD ZITKS Akhmedou MAKHMUD SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ■Burial 2 □ Cremation 3 □ Removal from State JAN. 7, 2007 FREDERICK MD. 4 Donation 5 Other (Specify) BLAMIC Com. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GARY L. ROLLINS FUNDALITUME Gay X. FREDBRICK MD ZITOI 110 WEST SOUTH ST 23a. Part1. Enter the diseate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician OCOVAL /Medical Due to (vr as a consequence of): Examiner Trial Dequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence burial-trar Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 25 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 24 hours after death. e Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 723 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DR. M. Khalid Waseem

31. Date filed (Month, Day, Year)

1126 Opal Court Hugerstown Md.

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To the Hospitel or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physicien and	completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit	

Homewood at Crumland Farms  5. Social Security Number   8. Sex   577-22-2146   10   10   10   10   10   10   10   1	2007 5:50P M Country of Death  Frederick  9. Birthplace (State or Foreign Country) Washington, DC  10d. Inside City Limits 1 Yes 2 X No zen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White
Red   Acton   Janaury   Acton   Janaury   Acton   Janaury   Acton	2007 5:50P M Country of Death Frederick 9. Birthplace (State or Foreign Country) Washington, DC  10d. Inside City Limits 1 Yes 2 X No zen of What Country? USA  14. Race - American Indian, Black, White, etc.  Specify: White
Homewood at Crumland Farms  Funeral Director  Social Security Number   5. Social Security Nicolal Security Number   5. Social Security Nicolal	9. Birthplace (State or Foreign Country)  Washington, DC  10d. Inside City Limits  1 Yes 2 X No  zen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White
Social Security Number   S.	9. Birthplace (State or Foreign County) Washington, DC  10d. Inside City Limits 1
Director    The control of the contr	Country) Washington, DC  10d. Inside City Limits 1  Yes 2 XNo  zen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White
John Acton/Son  4213 Bar Harbor Place, Olney, MD  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  1   Burial 2   Cremation 3   Removal from State   Date   Date	1 ☐ Yes 2 XNo  zen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White  Ind of Business/Industry
John Acton/Son  4213 Bar Harbor Place, Olney, MD  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  1   Burial 2   Cremation 3   Removal from State   Date   Date	USA  14. Race - American Indian, Black, White, etc.  Specify: White
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John Acton/Son  4213 Bar Harbor Place, Olney, MD  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  1   Burial 2   Cremation 3   Removal from State   Date   Date	nd of Business/Industry
John Acton/Son  4213 Bar Harbor Place, Olney, MD  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  1   Burial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Stauffer Funeral Service Licensee  22a. Part Fine the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)    Due to (or as a consequence of):   Character	
John Acton/Son  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1   Durial 2   Cremation 3   Removal from State   Date	Rankina
John Acton/Son  4213 Bar Harbor Place, Olney, MD  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  1   Burial 2   Cremation 3   Removal from State   Date   Date	Rankina
John Acton/Son  4213 Bar Harbor Place, Olney, MD  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  1   Burial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Stauffer Funeral Service Licensee  22a. Part Fine the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)    Due to (or as a consequence of):   Character	Banking
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John Acton/Son  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1   Durial 2   Cremation 3   Removal from State   Date	Hummer
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23a. Part Find the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Change	cation - City or Town, State
23a. Part Enter he disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Chanic Abstruction Primary Office.	erick, MD
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if any, leading to immediate Due to (or as a consequence of):	Interval Between Onset and Death  Tunk  Types  5 years
TF FEMALE: 23c If was outcome of pragrams	3d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco us	se contribute to the cause of death?  No 3 Probably 4—Unknown
Atrial function  1 Yes 2	
Arenic  23e. Did tobacco us  1 Yes 2  24a. Was an autopsy performed?  1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
25. Was case referred to medical examiner?  Hospital:   Inpution: 2   Inpution: 2   Inpution: 2   Inpution: 3   Input   Input	
24a. Was an autopsy performed?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  1   Yes   25   No    26. Place of Death (Check only one)  1   Yes   25   No    27. Manner of Death  1   Matural   5   Pending investigation    28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  M   1   Yes   2   No    28c. Injury at Work?  M   1   Yes   2   No    28d. Describe how injury at Work?  M   1   Yes   2   No    28d. Describe how injury at Injury at Work?  28d. Describe how injury (Month, Day Year)  28d. Place of Injury - At home, farm, street, factory, office  28d. Location (Street and City or Town, State)	
28a. Date of Injury 28b. Time of Injury at Work?  28d. Describe how injury at Work?	Number or Rural Route Number,
29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier 29d. Date 1/8	signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Martha Pierce 300 W. Ninth Street, Frederick, MD 21701	1/07
State Registrar  31. Date filed (Month, Day, Year)  JAN 0 9 2007  32. Figistrar's Signature	7/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3, 2007 11:05 A M January Catherine Elizabeth Adams /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 179 Oakwood Road Conowingo Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 T F July 24, 1930 76 Director 212-28-2647 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itams 23s or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Cecil Conowingo 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 179 Oakwood Road 21918 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Schuman Lucy Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Debbie Carr/Daughter PO Box 61, Conowingo, MD 21918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Brookview Cemetery 1-8-2007 Rising Sun, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature o Funeral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral Home. P.A. 111 S. Queen Street, Rising Sun, MD 21911 uchang s that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part1. Enter the diserse, or complice shirck, or heart failure. List only on y Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE LUNG **Physician** /Medical Due to (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2☐Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 PNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Mountain Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No P 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; After 1 Natural 5 Pending To the musping within 24 hours after death.

To the Funeral Director: All 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the ! 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Receptor MC 1/5/2007 345344 30. Name and address of person who implifted cause of death (Item 23a) (Type, Print) AVE HAVRE DEGRACE, MO 21078 SURESH DHANJANI 80 622 S, UDION

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2007

			1 For State Registrar	State of M	laryland /			of Health of Death		/lental Hy	/giene Reg. No	00	n 7	015	1 7
	Physic	ian	1. Decedent's Name (First, Middle, L	•						2. Date of De		V	_ Year	3. Time of De	
	/Medi	cal	Roy Allen Ande				1 4			Januar		200		2:00 A	М
	Exami	ner	4a. Facility Name (If not institution, g 13180 Hessong Br		)		Thurmo	wn, or Location	of Death				of Death r <b>ic</b> k		
	Funeral				ge (In yrs. last bi	irthday)	If Under 1 Y	ear If Under		8. Date of Bir	rth			lace (State or F	oreian
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	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Lo	ocation								
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	<b>Funeral Director</b>	13180 Hessong Bri	dge Road			21788	1			USA			-,-	
	r dea	nei	11. Marital Status	12. Was Decedent Armed Forces	7	13.	Was Decedent	of Hispanic Ori Cuban, Mexicar	igin? (Sp	ecify Yes or No	)-		- America		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☑Yes 2 ☐ If Yes, Give Year or Dates	No 061 64	J	1 □ Yes 2 🔀			rticari, etc.)		Specify.	k, White, e		
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Maryland	nd 2 should be filed within alth and Mental Hygiene. 27 Is marked other than ir traumatic event, the Me		19a. Informant's Name/Relationship		I			reet and Numbe							
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E O	Pages nent of P int: If ite		1 ☐ Burial 2 Marcremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	T .			1							
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		21. Signature of Funeral Service Lice		Chesar	peak	ce Crem	atory :	01/0	6/07	Belt	svil	L1e,	MD	
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P			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that cause y one cause on each l	d the death. Do	not ente	er the mode of	dying, such as	cardiac d	or respiratory ar	rrest,	LIKS		Approximate Interval Between	
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	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		ge Renal		50350								
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Box	eath catterd	Physician/Mec	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal death		Ectopic pregna				2		of deliver		
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5∐	Other (specify	)				Mon	נוו ב	Day Year	
σ.	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as		Part II. Other significant conditions	contributing to death b	ut not resulting in	the un	derlying cause	given in Part I.		23e. Did to	bacco us	se contrib	oute to the	cause of death	12
Division or Vital Records,	quires nn sign uld be	Completed by	stopped Hemodialy	sis on 12/	31/06					1 🗆 Y		_		bly 4 □Unkn	
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2	Attending Physician: r death. ector: After this certific by the funeral director,	2	1 ☐ Yes 2 🛣 No		nt 2□ER/Out	tpatient	3□ DOA	041		ne 5 <b>X</b> Resid		Other	(Specify)		
ü	ding F	io	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da		ime of njury		njury at Vork?		8d. Describe h	ow injury	occurre	d		
is.	death death ctor: y the	Certification:	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 200 Place of init	In/ - At home for	m etro		Yes 2 N		01.1					
<u>S</u>	affor A affer Dire	ertii	4 ☐ Homicide determined	building, et	c. (Specify)	III, Stie	et, factory, offic	ce	2	8f. Location (S City or Town	treet and n, State)	Number	or Rural I	Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 🛚 Certifying Pt	nysician: To the best	of my knowledge	, death	occurred at the	e time, date and	place, a	and due to the c	ause(s) a	and man	ner as stat	ed	
	in 24 in 24 in EL ine Fu	edical	(Check only 2 ☐ Medical Examone)	miner: On the basis of and manner sta	examination and	d/or inv	estigation, in m	ny opinion, deat	h occurre	ed at the time, o	date and	place, an	id due to t	he cause(s)	
	with To t	Σ	29b. Signature and title of cortifler		110		-	ense number		!			Month, Da	- '	
600	, .		CATTU	AUN N	(1)			0475	56		Janu	ary	5, 20	007	
0	+/	1	30. Name and address of person who												
	Sta		William H. Johnson 31. Date filed (Month, Day, Year)		2 Thomas ar's Signature	Jo	nnson I	r. Suit	e 20	J2 Frede	eric	k, M	D 217	02	
	Registra			2007	we !	6	and s								

			For State Registrar	State of Maryla		epartment of C <i>ertificate o</i>		d Mental Hy	/giene Reg. No.2	07	01548
	Physici	an	1. Decedent's Name (First, Middle, La		<del>-</del>			2. Date of Do Month Januar	eath Day	Year 2007	3. Time of Death  2005 PM
	/Medio		Norman Hollenber  4a. Facility Name (If not institution, given			4b. City, Town	n, or Location of De		4c. County		20001
	Funeral Director	er	Washington Count 5. Social Security Number 6. 5	y Hospital		Hager	stown ar If Under 24 F	rs. 8. Date of Bi in. (Month, D	Wash:	ingto 9. Birthpla Count	ace (State or Foreign ry)
20 5	The second section		219-05-0567 Usual Residence of Decedent	00				UCT.	14 1918	Mar	yland
	aryland show	٦	10a. State 10b. County	10c. C	ity, Town	or Location	·			10	ld. Inside City Limits 1 ☐ Yes 2 ☑ No
	h the M r 28a-f r notifle	Director	Maryland Washir  10e. Street and Number	gton W	illia	msport 10f. Zip Cod	e		10g. Citizen of V	Vhat Count	41
	th wit 23a o ist be		16505 Virginia A	venue		217	95		USA	A	
۵	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 11∑Yes 2 ☐ No		13. Was Decedent of If Yes, specify C	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No uerto Rican, etc.)	o- 14. Raci Blac	e - America k, White, e	tc.
-003	hours a	ed by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		ecedent's Usual Oc			Specify 16b. Kind of Bu		White
215-0036	rithin 72 ne. han "na e Medic	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	College (1-4or 5+)	1 (	Give kind of work do life. DO NOT use ret	ne durina most of i	working			·
2	lled w Hygier her ti nt, th	ပ္	12 17. Father's Name ( <i>First, Middle, Last</i>	2		Sales	18 Mother's N	Name (First, Middle	Electri		Supply
Maryland	d be f ental h <b>ced ol</b>	To Be	Norman Jacob Ben					hryn Holl		•	
ar Z	shoul ind M i marl umatl	F	19a. Informant's Name/Relationship (		19b. l	Mailing Address (Stre					Code)
	and 2		Norman J. Bentz		10	4 Leanne	Drive, M	iddletowr	n. Delawa	are 19	709
Baitimore,	of He of He if Item or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐		Place of [	Disposition (Name of crematory or other)		Date	20c. Location -		
Ē	: Pages tment of tant: If Ik	١.,	4 □ Donation 5 □ Other (Special	(y)	Rose	Hill Ceme			Hagersto		1d.
n n	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	1see MM		22. Name and Ad		Minnich			
			23a, Part1. Enter the disease, or com	plications that caused the de		415 E. W				_	
	Physician <sup>*</sup>	is 7	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.  RESP							Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conse							
	Examiner	L	Sequentially list conditions,	b. SE PS		\.					
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury	Due to (or as a conse							
	execu n and al-trai	Examiner	that initiated events resulting in death) Last	C. Due to (or as a conse							
08/00	ficate be executed physician and is the burial-transit	edical		►d							
O. Box 68	attending for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death	3 ☐ Ectopic pregna 5 ☐ Other (specify,			23d. Dat	e of deliver	y Day Year
7.	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions				given in Part I.		tobacco use contr		
ecords,	law requit as been s 2 should		ACUTE RENAL F		DRAT	ion,		1			bly 4 □Unknown sy findings available
ř	The ate has page	Completed						— auto	opsy pormed?	prior to com leath?	pletion of cause of
VII	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	350/0.4		Othor:	Death (Check only			
0 UC	lng (fte	ion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 ☑Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Ti	me of ury 28c. Ir	njury at Vork?	g Home 5 Res	idence 6 □Othe how injury occurr		<u> </u>
UIVISION	or Attencter death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 290 Place of injury At I	home, farn cify)		□Yes 2□No	28f. Location ( City or To	(Street and Numbe wn, State)	er or Rural	Route Number,
	e Hospital (124 hours at E Funeral Dietely filled i	edical C	29a. Certifier 1 ☐ CertifyIng Pi (Check only one) 2 ☐ Medical Exam	nysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, nation and	death occurred at the for investigation, in m	e time, date and play ny opinion, death o	ace, and due to the ccurred at the time	cause(s) and ma , date and place, a	inner as sta and due to	nted. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date signed	i (Month, D	ay, Year)
			Machour H	woly, MD		D6	2562		1-10	5-07	7
54	1-4+1		30. Name and address of person who WASMINGTON COU			ype, Print) MA EAST AI					
וע	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature			317661	77714 675 10		7 -1140
	Registr	ar	JAN 11	2007 Janeen	A.	South					

		-	For State	State of Marylan	·	t of Health and leath	Mental Hygier	/ 11 11 1	01549
	Physici		1. Decedent's Name (First, Middle, Last	1	R	4	2. Date of Death	Day Year	3. Time of Death
	/Medic	al -	Shirley	Virgin	ria D	VICE	Jan.	4c. County of Deat	15:30 AM
	Examin	er	4a. Facility Name (If not institution, give	. 01.00	46. City,	Town, or Location of Deat	n	talbo.	, 
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.			8. Date of Birth (Month, Day, Yea		nplace (State or Foreign
	Director		217-28-3531	M 200 F 7	Yrs. Months	Days Hours Min.	Jan. 30	1932 Ma	untry)
	و پ		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Location				10d. Inside City Limits
7	ahov	5	44 5	7		/			1 □ Yes 2 ₺No
7	the N	rect	// D Talbo	<i>†</i>	Easton 101. Zip		10g.	Citizen of What Co	untry?
2	3a or	by Funeral Director	10279 Baston	Cliff RO	and	2/601		USA	
7	death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Dece	dent of Hispanic Origin? (S cify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
9	or Its	3	1 Never Married 2 Married	1 ∐ Yes 2 ∰No If Yes, Give	1 ☐ Yes			Specify:	10.10
21215-0036	hours after death with the Maryland tural; or Itama 23a or 28a-f ahow at Exeminat count to notified at	D P	3 Widowed 4 Divorced  15. Decedent's Edu	Year or Dates:	16a. Decedent's Usu	al Occupation	16b	Kind of Business/	Industry
-5	in 72	Completed	(Specify only highest grad	e completed)	(Give kind of wo	ork done during most of wo se retired)	rking		
212	d within jiene. r than	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Domes	tia Wor	K P	rivate	Residence
	be filed tal Hygi d other avant, I	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, Maid	en Sumame)	
yla	Ment Ment arkac	၉	Walter Mi	Iton Bai	ley	Bear	rice s	Kinn	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryian it of Heelih and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f ahow if item 27 is marked other than "natural", or itematic avant, the Madical Examinal must be notified at		19a. Informant's Name/Relationship (T)	D.	1/9b. Mailing Address	s (Street and Number or R	_		1D 21601
	1 and Heelt am 2 than		20a. Method of Disposition		Place of Disposition (Na			Location - City or	
nor	Pages nent of int: If it		1 Burial 2 Cremation 3 □I 4 □Donation 5 □Other (Specify,	Removal from State	cemetery, crematory or c htteMarsh	~ 1 / 1	9107 5	x < font	Maryland
Baltimore,	교통론를 .		21. Signature of Funeral Service Licens	ee .	00 11	of Address of Pholibs			nargiaria
ä	Depermine Depermine Suny is su		Danelle.	C. Henr	Henre 510 W	y Funeral Jashington	St. Canb	ridge. N	10.21613
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deal	Do not enter the mod	de of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	/ \- \	nai o Car				20 months
	/Medical Examiner		resulting in death)	Due to (or as a consec		v C t V t C V t C C			
	Examine	Ļ	Sequentially list conditions,	b. Due to for as a consec	were offe				
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	00010 (01 00 0 00100	quelice ory:				
	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c.  Due to (or as a consec	quence of):				
760,	ate be executed hysicien and he burial-transit	cail		d					
89	leath certificat ettending phy ifor use as th		IF FEMALE:					,	
Вох	death certifica e ettending ph d for use as th	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Feta	al death 3 Ectopic p			23d. Date of del Month	ivery Day Year
о. П	0 0 0	Physician/Med	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	4 Pregnant at time of of 9 Unknown	death 5 Other (s)	pecify)			
<u>α</u>	E 20 8	4	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
sp.	uires signe lid be	d by					1 ☐ Yes	2)X No 3 □ Pr	obably 4 🗍 Unknown
00	w requir s been s should	lete					24a. Was an	24b. Were at	itopsy findings available
Re	The laverete hes	Completed					autopsy performed 1 ☐ Yes 2 ☑	? death?	completion of cause of
of Vital Records,		Be C	25. Was case referred to medical examiner?				eath (Check only one)		
× >	g : 5	2	1 Yes 2 No		ER/Outpatient 3 D		Home 5 Residence		cify)
		ë.	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe how i	njury occurred	
isio	Attanding r death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	M M	1 Yes 2 No	28f. Location (Stree	and Number or R	ural Route Number.
Division	of or Attand effer death Diractor: d in by the f	Certification:	4 Homicide determined	building, etc. (Speci	(fy)	y, oo	City or Town, S.		
	To the Hospitel or / within 24 hours effer To the Funeral Direct completely filled in b			vsician: To the best of my kn iner: On the basis of examin					
	To tha H within 24 To tha F complete	Medical	one)	and manner stated.					
	To To To	-	29b. Signature and title of certifier	000 1	29	c. License number		Date signed (Mont	100-
7				el Midel	230) (Time Print)	D4723	2	11104	12001
		0	Dr. Mary DeShiel			e 101, Easton	n,MD 21601		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign					
	Regist	rar	JAN 0 5	2007	K has	M.			

DHMH 17 Rev 1/2001

ORIGINAL

		For Stete Registrer	State of Marylan	d / Depa		lealth and M	lental Hygi	ene	01550
		Decedent's Name (First, Middle, Last	)		Timouto or		2. Date of Death		3. Time of Death
Physic /Medi	cal	Catherine  4a. Facility Name (If not institution, give	Hall Bell		4b. City, Town, o	r Location of Death	January	3,2007	1:20 P
Exami	ner		,						
Funeral		1402 Race Street  5. Social Security Number 6. Se	x 7. Age (In yrs. I	ast birthday)	If Under 1 Year		8. Date of Birth	Day Year  3, 2007  4c. County of Dea  Dorch  (ear) 9. Bit  (1944 M.  G. Citizen of What C  USA  14. Race - Am  Black, Whi  Specify:  5b. Kind of Business  Health  aiden Sumame)  City or Town, State,  ryland 21  co. Location - City or  alisbury,  Maryland  21  23d. Date of de  Month  Cco use contribute to  2 No 3 12  24b. Were a  prior to  death;  co. Location - City or  alisbury,  Maryland  3.  23d. Date of de  Month  Cco use contribute to  2 No 3 12  24b. Were a  prior to  death;  co. Location - City or  alisbury,  Maryland  3.  23d. Date of de  Month  Cco use contribute to  2 No 3 12  24b. Were a  prior to  death;  add?  See 6 Other (Spering)  rinjury occurred	rthplace (State or Foreig
Director			<sup>™</sup> XX <sup>F</sup> 62	Yrs.	Months Days	Hours Min.	July 12,	1944 N	Maryland
yland		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
Mar.	Į.	Maryland Dorchest	er	Can	bridge				YSYes 2□No
r 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
h wit		1402 Race Street			216	513		USZ	1
dea	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.		lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - Arr	erican Indian,
hours after death with the Maryland tural, or items 23a or 28a-f show al Examiner must be notilised at	by Funeral	1 Never Married 2 Married	1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2, No	Specify:	ricali, dic.j		White
72	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing 1	6b. Kind of Busines	s/Industry
within jiene. r then "	E	12	3		Registere	ad Nurse		Health	care
illed Hygi other	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle, M.		
Mental Mental Med c	To B	Willard Perry	Hall			Anna	Rippons		
2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Maili	ng Address (Street			City or Town, State,	Zip Code)
tra tra	1	Lisa D. Willey	Daughter	1402	Page Str	reet Cambr	ridan Ma	ruland 21	613
- I = =		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of				
80 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	temoval from State		matory or other place	1	/07	- 1lansans	M
		21. Signature of Funeral Service Licens			Cremator  Name and Addre		07 5	allsbury,	Maryland
permit. Depertrimportu		21. Signature of Purietal Service Licens					P.A.		
40.44		23a. Part1. Enter the disease, or comp	)		00 Locust	Sfreet (	ambridge	, Marylan	d 21613 Approximate
Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequ	nar	Art	ery Z	929 EC	Interval Between Onset and Death	
executed be executed by spicion and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)						
The law requires thet the death certificate site has been signed by the ettending physicage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	<i>'</i>			elivery Day Year
uires thet signed b Id be deta	þ	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.			to the cause of death?
The law requir ete has been si page 2 should	Completed						24a. Was an autopsy	prior to	autopsy findings available completion of cause of
									s 2 No
icien: T certificat rector, p	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	200	h (Check only one		
ding Phys h. After this funeral dir	lon: To	27. Manne Death 1 Vatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injur	4   Nursing no	me 5 Hesider 28d. Describe how		ecify)
ten for:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str			28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
To the Hospital or At within 24 hours efter or To the Funeral Directompletely filled in by	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno- iner: On the basis of examinal and manner stated.	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	me, date and place, pinion, death occurr	and due to the cau	use(s) and manner a te and place, and du	as stated. se to the cause(s)
To the within 2 To the complet	Me	29b. Signalure and title of certifier	- Julion		29c. Licens	e number	29	d. Date signed (Mor	nth, Day, Year)
5 vit	1	20 1hm	m'n					1	
		Draviou	MD		1001	7		01103/	100
			ompleted cause of death (Item	23a) (Type,	Print) HURCRA	ST. OF	MBRED	GE, ME	21613
St Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 0 4	32. Registrar's Signa	ture	lovele				

			1 = For State Registrar	State of	Marylan			t of Health e of Deat		lental Hygi	200	7	015	51
			1. Decedent's Name (First, Middle, La	ast)						2. Date of Death Month	Dav	Year	3. Time of	
	Physici /Medic		Aloise Jean	ette Will	Lumsen	Beatty	7			January	7, 200	7	0350	M
	Examir		4a. Facility Name (If not institution, gi					Town, or Locatio			,		_	
_			Harford Memori			1		vre de	Grace er 24 Hrs.	O Date of Birth	1			. C
	Funeral Director		212-20-6697	Sex 7 1 M 21☑ F	7. Age (In yrs. 82	Yrs.	Months	Days Hours		8. Date of Birth (Month, Day, Dec. 21,	1924	Cou	olace (State o ntry) Maryla:	nd 
	land land		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside Ci	ty Limits
	a-fah	ctor	Maryland Ceci	.1			Po	rt Depos	sit				1 🗌 Yes	2 <b>X</b> No
	or 28	Director	10e. Street and Number				10f. Zip			10	•		•	
	ath w	ā	33 York Drive					219		N				
Ç	Baltimore, Maryland ZIZIO-UUSO  sermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itama 23s or 28s-f show my hipury or other traumatic event, the Madical Examiner roughle multised at  DRES.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes If Yes, Give Year or Da	ces? 2 ⊠ No ∋			dent of Hispanic Color Cuban, Mexicolor Cuban,		ecify Yes or No- Rican, etc.)	Black	k, White,		
7	2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usua	al Occupation	act of work	ing 1	6b. Kind of Bu	siness/Ir	ndustry	
AM	Maryland ZIZI3-0030 d 2 should be filed within 72 hours aft th and Mental Hygiene. If is marked other than "natural", or traumatic avant, the Madical Experi	Be Completed by	(Specify only highest given the state of the	College (1-	4or 5+)			rk done during m se retired) v/BRL	OST OF WORK				-	
0	iled v Hygie ther t	S	17. Father's Name (First, Middle, Las	(t)		560	recar	· · · · · · · · · · · · · · · · · · ·	ther's Name			·		
350	ire, Maryland ZIZIs at and 2 should be filed within of Health and Mental Hygene. Item 27 is marked other than other traumatic event, The Maryland Health and Health a	To Be		" Willumser	า					Ida Tu	g. No.  Day Year 7, 2007  4c. County of Death Harfor 1924  G. Citizen of What County 1924  In 10  In 1			
0	aryida should ind Men ind Men in marke	۲	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street and Num	nber or Run	al Route Number,		State, Zi	code)	
	and 2 alth a alth a 27 to		Jeffrey Beatty (	son)		54 Tu	lip I	rive, C	onowi:	ngo, Mary		2191	.8	
	of He roth		20a. Method of Disposition 1 □ Burial 2 🔁 Cremation 3	Removal from S	20b. F	Place of Dispo cemetery, cre	osition (Nar matory or c	ne of ther place)	i	Date 2	Oc. Location -	City or T	own, State	
<u></u>	Pages Pages ment of lant: If it		4 Donation 5 Other (Spec	ity)	R.	A. Ferri				11/07 W	est Ches	ter,	Pennsylv	<i>r</i> ania
7/	baltimore, permit. Pages 1 a Department of Her important: If Item any injury or othe		21. Signature of Funeral Service Lice	anseig MUEII	ION, S	Le	ee A.	d Address of Fa Patters ille, Ma	on &	Son Fune: d 21903	ral Hom -0766_	e, I	P.A.	
_			23a. Part1. Enter the disease, or cor shock, or heart failure. List ont	mplications that ca y one cause on ea	used the deat ach line.	h. Do not en	ter the mod	le of dying, such	as cardiac	or respiratory arre	st,		Approximat Interval Bet Onset and	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a (	FLIO	BLAS	TOP	MA						
	/Medical Examiner		resulting in deathy	Due to (d	or as a conseq	uence of):								
rall)		PE	Sequentially list conditions,	b. Due to (c	or as a conse	uence of								
1 1	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events								Day 7, 2007  4c. County of De Harr  Year) 9. E 1924  Dg. Citizen of What I  U.  14. Race Ar Black, W Specify:  16b. Kind of Busines berdeen P berdeen, Maiden Sumame)  dor  City or Town, State yland 21 20c. Location - City  West Chester  ral Home, -0766  sst,  23d. Date of Month  I/C7  Dacco use contribute as 2 1 6 3   Control of Month  I/C7  Dacco use contribute  Dacc			
	6U, be executed ician and burial-transit		resulting in death) Last	Due to (d	or as a conseq	quence of):								
U	5 × 6	ical		d										
1015	Hecords, P.O. BOX 68 The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₹ No 9 □ Unknown		nth 2 ∏ Feta antat time of c	al death 3[	⊒Ectopic p ⊒ Other (s¢		TAP	PLICABLI	G Mor	nth		Year CABLE
< !	that the de ed by the detached	Ph	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	underlying o	ause given in Pa	ırt I.	23e. Did tob				
~	COLGS, w requires t been signe should be		HYPOT	ENSIC	N					1 ☐ Ye	s 2 100	3 Pro	bably 4 🗍	Unknown
+	aw reas bec	Completed	RENA	AL FA	ILUR	E				24a. Was an	24b. V	Vere aut	opsy findings	available
+!		E O								perform 1 □ Yes 2	ed? d	leath?	2□ No	
D	/Ita	Be	25. Was case referred to medical examiner?	Use shell				7	ace of Deat	h (Check only one	)			
36	Of VITA Physicien: this certifica ral director, r	2	1 Yes 2 No	Hospital:	tatient 2				Nursing Ho				fy)	
W		ion	27. Manner of Death  12 Natural 5 Pending investigati	(Monti	h, Day Year)	28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes —2	₽No	200. Describe no	w injury occurr	eu		
	DIVISION  or Attending after death. Director: After	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	of Injury - At h	ome, farm, st fy)				28f. Location (Str City or Town		er or Rui	ral Route Nuп	nber,
'	DIVI To the Hospitel or At within 24 hours after of To the Funeral Direct completely filted in by	dical Ce	29a. Certifier 1 Certifying R (Check only one) 2 Medical Ext	Physician: To the aminer: On the ba	sis of examina	owledge, dea ation and/or in	th occurred nvestigation	at the time, date i, in my opinion, o	and place, death occur	and due to the ca red at the time, da	use(s) and ma te and place, a	nner as and due	stated. to the cause(s	s)
	othe othe	Med	29b. Signature and title of certifier	and main	o. stated.		29	c. License numb	er	29	d. Date signed	(Month	Day, Year)	
	⊢ ≯ ⊢ ŏ		Anuras	a So	ad	•	Т	00605	520		1/7/2	-00	7	
	77		30. Name and address of person wh	A		m 23a) (Type					-			
			ANURAAG	5001				NUT	LA	NE A	BERD	EE	NI	1.D
	St Regist	ate rar	31. Date filed (Month Day, Year)		egistrar's Sign									

		ľ	For State Registrar	State of I	Maryland		artment rtificate					jiene leg. No.	007	01552
	* 3		1. Decedent's Name (First, Middle, La	st)						2	2. Date of Dea	ith Day	Year	3. Time of Death
	Physicia /Medic		CARLENE N	MARIE	BEALL					J	anuary	3	2007	21:41 M
	Examin		4a. Facility Name (If not institution, give						Location					
			Washington Adve						Par If Under					
ш	Funeral		,	Sex 7. 1 □ M 2 16 F	Age (In yrs. I	ast birthday) Yrs.	If Under Months	Days	Hours	Min.	B. Date of Birth (Month, Day Dec • 8	Year)	Cou	intry)
	Director		579-20-5018 Usual Residence of Decedent		03						Dec. o	1,5,	ZJ Fla	Lytana
	land ow		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
	the Marylar 28a-fehow notified at	to	Md. Montg	omery	K	ensing	gton							1 ☐ Yes 2 🗷 No
	r 28s	Irec	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What Co	untry?
	h with	D	3519 Nimitz Ro	ad				2	20895	5		Unit	ted Sta	tes
	deat	Funeral Director	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S	S. 13.	Was Deced	lent of His	spanic Or	igin? (Spec	ify Yes or No- ican, etc.)	14		
9	or ite	F	1 Never Married 2 Married	1 Tes 2 If Yes, Give Year or Date	<b>X</b> No		1 ☐ Yes 2		Specify.				anaih	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow he Madical Exeminer must be notified at	d by	3 XWidowed 4 □ Divorced		es:	16a Dana	dente Herre	1.0	tion			16h Vin		
15-	"nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usua kind of wor DO NOT us	rk done d	uring mos	st of working	7	TOD. KIII	2 01 003111633/1	ildustry
12	withi lene. than	mo	Elementary/Secondary (0-12)	College (1-4)	or 5+)	Sal	es Per	rson				Ref	tail St	ore
	Hygother ent,	Be C	17. Father's Name (First, Middle, Last	)					18. Moth	er's Name (	First, Middle,	Maiden S	iumame)	
a	fental rked rlc ev	To B	Carl Springi	rth					Maı	rie	Menear			
Maryland	and N		19a. Informant's Name/Relationship											
	and 2 salth in 27 i		Richard D. Bea	11 / Son					ird (					
ore	of He of He fitan		20a. Method of Disposition 1 □ Burial 2 1 Cremation 3 □	Removal from Sta	Ce	tace of Dispo emetery, crea	sition (Nan matory or o	ne of ther place	9)	Da				
ΔĒ	Pag ment ant: I		4 □Donation 5 □ Other (Speci		Met	ropol				1/5/				.a, Va.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or iteme 23a or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Lice	Bar,	her	22	Name an Muri P. O	d Addres e I H . Bo	s of Facili Bail ox 50	rber F	uneral aytons	Home ville	Town, State, Zip Code) e, Md. 21754 cation - City or Town, State exandria, Va.  Approximate Interval Between Onset and De  3d. Date of delivery Month Day Yes  se contribute to the cause of deal or spring to completion of caude deal?  24b. Were autopsy findings averaged to the Completion of caude and Personal Caud	20882
	.s.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the death h line.	n. Do not ent	ter the mod	e of dying	g, such as	s cardiac or	respiratory ari	rest,		Interval Between
	Physician		Immediate Cause (Final disease or condition	· Po	1200 th	to ac	nia							Onset and Death
7 [6]	/Medical		resulting in death)	Due to (or	as a consequ	uence of):								
140	Examiner		Sequentially list conditions.	o. Uts	erine		ncer	wit	ey p	letas	tasis	<b>*</b>		
	D #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequ		2.10							
	and I-tran	Examiner	that initiated events resulting in death) Last		PERTS as a consequ		010							
8760,	cate be executed obysicien and the burial-transit	四田	l		ABET		MC	ITI	<					
687	phys phys s the	gg	. <u> </u>	d. 01	nbe	1 1 -	1,00							
Box (	law requires thet the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, outcome								23	d. Date of deli	very
B	death e etter d for u	clar	in the past 12 months?	4 Pregnan	n 2∏Fetal It at time of de		∃Ectopic pr ∃ Other (sp						Month	Day Year
P.O.	t the c	hys	9 Unknown	9□ Unknow	n									
	w requires thet been signed to should be deta		Part II. Other significant conditions	contributing to deat	h but not resu	ulting in the u	nderlying ca	ause give	n in Part	t.	23e. Did to	bacco us	e contnbute to	the cause of death?
rds	quire an sig	edt	HYPONATRE	MIA.							1 □ Y	es 2 🗆	No 3□Pro	bably 4 Minknown
00	aw re	plet									24a. Was a autop		24b. Were au	topsy findings available
Ä	The law ste has page 2 s	Completed by									perfor	meg/?	death?	
of Vital Records,	ician: Th certificete rector, pag	Вес	25. Was case referred to medical examiner?						26. Plac	e of Death	Check only o	10)		
>	Physician: r this certifice ral director, p	2	1 ☐ Yes 215KNo	Hospital: 1 Dinp	atient 2 1	ER/Outpatier			4 🗆 14					afy)
2	Jing P. After ti funera	ö	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of I (Month,	Injury Day Year)	28b. Time o Injury		8c. Injury Work			ld. Describe h	ow injury	occurred	
Sio	Attending ir death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not it	20			М		/es 2 [		26 1 (6	·	M	
Division	or At after d Direct in by	Certification:	4 Homicide determined	286. Flace of	Injury - At ho , etc. (Specify		reet, factory	r, office		28	City or Tow		Number or Hu	rai Houte Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funaral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier TX Certifying P	hyeicien: To the ba	ast of my kan	wledge doct	h occurred	at the tim	e date a	nd place as	nd due to the o	alleg(e) a	nd manner as	stated
	To the Hospital within 24 hours a To the Funaral I completely filled	edical			is of examinat									
	o the	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	signed (Month	, Day, Year)
	L		Kajal Da	Gupte			0-0	006	469	19	1	13/	07	
	4		30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print)	Kaja	1 Da	squpta	a, M.D.			
			7600, Ca	roll Av	سوسو	_ 7	Tak	on	a Pe	erk.	, M.D.	).	20912	
4.7	Sta		31. Date filed (Month, Day, Year) JAN 08 20	10.7 32 Reg	istrar's Signal	ture								-
	Registr	ar	JAN VO ZU	JUI JUI	10 D	S GO	Ser!							

DHMH 17 Rev 1/2001

ORIGINAL

			1 State	State of Maryland / D	epartment o		-	2007	01553
	2		Registrar  1. Decedent's Name (First, Middle, Last		Oerimoate c	, beath	2. Date of De	Reg. No. UU /	3. Time of Death
	Physici		Tvan	Bernard BRENDLER			Month January	4. 2007 Year	3:12 A M
	/Medic Examir		4a. Facility Name (If not institution, give			n, or Location of Death		4c. County of Dea	
			Aspenwood Assisted	Living		er Spring		Montgo	nery
	Funeral		5. Social Security Number 6. Se	IM 2□F	hday) If Under 1 Ye Yrs. Months Da		<ol><li>Date of Birl (Month, Da</li></ol>	y, Year)	rthplace (State or Foreign country)
	Director		577–30–2383 Usual Residence of Decedent	79	113.		Feb. 1	3, 1927 Wa	shington, DC
	/land ow at		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Mary B-f sh	ţo	Maryland Montgon	ery Silv	er Spring				1 ☐ Yes 2 X No
	th the or 284 e not	Jirec	10e. Street and Number		10f. Zip Coo			10g. Citizen of What C	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medisal Examiner must be notified at	Funeral Director	14400 Homecrest Ro			20906			
	er deg	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent If Yes, specify (	of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Am Black, Wh	
36	rsafte I",or xa⊞h	by F	1 ☐ Never Married 2 ☐ Married 2 ☐ Warried 2 ☐ Married 2 ☐ Divorced	1♥ Yes 2 □ No lf Yes, Give W W II Year or Dates: W W II	1 ☐ Yes 2 🔀	No Specify:		Specify:	white
8	2 hou	ed	15. Decedent's Edu		Decedent's Usual Oc	cupation		16b. Kind of Business	s/Industry
75	hin 7; an "n Medi	ple	(Specify only highest grad	College (1 Apr 51)		one during most of worki tired)	ng	Tnouvence	
7	yd wit	PO.		4' 1	nsurance A			Insurance	
2	be file tal Hy d oth	Be Completed	17. Father's Name (First, Middle, Last) Charles	Brendler			e (First, Middle, ude Lev	Maiden Surname) V	
Baltimore, Maryland 21215-0036	should be fand Mental Band Mental Bandsked of umatic even	2							7: 0 11
Nar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7) Robert Brendler, S			eet and Number or Run ng House Rd			20852
e) O	1 and Healt em 2		20a. Method of Disposition		Disposition (Name of the control of		-	20c. Location - City o	r Town, State
nor	ages ant of t: If it		1 Burial 2 □ Cremation 3 ☑ F	removal irom State		rial Garden	,	Falls Ch	
Ħ	nit. Partme		21. Signature of Funeral Service Licens			dress of Facility  Ky Hebrew F			<u> </u>
ä	Dep Imp any					ку Hebrew F oll St., NW			20012
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. Do not not cause on each line.	not enter the mode of	dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Respiratory Fai	lure				Onset and Death
122	/Medical		resulting in death)	Due to (or as a consequence of					
١	Examiner	L	Sequentially list conditions,	Sarroidosis					
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	or):				
	xecut and il-tran	xan	that initiated events resulting in death) Last	C	of):				
8760,	cate be executed obysician and the burial-transit	dical E	(						
687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edic		0					
Box	that the death certificed by the attending prodetached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death	2 DEstanta arana	eng.		23d. Date of de	elivery
o.	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death	3 □Ectopic pregn. 5 □ Other (specif			Month	Day Year
P. 0.	at the by th	hys	9 □ Unknown						
<u>ທ</u>	w requires that been signed to should be deta	by F	Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause	given in Part I.		obacco use contribute	
ord	requir sen s nould	ted					1 🗆 '	Yes 2∏No 3∏F	Probably 4 ☐Unknown
ec	e 2 sh	Completed					24a. Was autoj	osy prior to	autopsy findings available completion of cause of
<u>=</u>	: The cate I	So					1□ Yes	ormed? death?	s 2 No
Ĭ	s <b>ician</b> certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Other:			Aggisted
ō	Phys r this ral dii	. To	1 ☐ Yes 2 No  27. Manner of Death	I Inpatient 2 ER/Ou	· ,	4 Inursing Ho		dence 6 Job Other (Sp how injury occurred	ecify)Assisted Living
Ou	ding h. After fune	tion	1X Natural 5 ☐ Pending 2 ☐ Accident investigation			Injury at Work? 1 ☐ Yes 2 ☐ No		. ,	_
Division or Vital Records,	Attending Physician: r death. ector: After this certifics by the funeral director, I	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, fall	rm, street, factory, off	ice	28f. Location (	Street and Number or I	Rural Route Number,
á	al or s after at Dir	Sert	4   Hornicide	building, etc. (Specify)			City or To	wii, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2			rsician: To the best of my knowledge					
	the H lin 24 the Fi	Medical	one)	and manner stated.					
	To the within To the comple	2	29b. Signature and title of certifier	- MA	29c. Lic	20 33/40		29d. Date signed (Mor	nın, Day, Year) )
	15+1		171	7-10	19,	5 33/96	/	1/4/07	
	, ,		30. Name and address of person who c			f+a1 2000	Do	ada ni ama	20007
	Qt.	ate	31. Date filed (Month, Day, Year)	Georgetown Univer		TLBI, 3800	keservo	oir Rd, NW	wasn, DC
	Daniet		JAN 0.5 200	17 Km. K	hall !				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	ryland				lealth a Death		lental Hy	giene) (	07	01554
	Dhyoisi		1. Decedent's Name (First, Middle, Last,	)							2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medi		John Ashleigh	Brittain							Janua		2007	6:52 A. M
	Examir		4a. Facility Name (If not institution, give	street and number)					Location of	of Death			inty of Deatl	
			Suburban Hospital					hesd					ıtgome	ry
	Funeral Director		5. Social Security Number 6. Security Number 15		(In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, D. Sept.	nth 10,1923	9. Birth Con	nplace (State or Foreign untry) inois
	D .		Usual Residence of Decedent		10- 01- 7	-								
	Maryia s-f shov	io	Maryland Montgome	ry	-	Town or Lo nesda	cation							10d. Inside City Limits 1 X Yes 2 ☐ No
	with the	i Direc	10e. Street and Number 7704 Marbury Road				10f. Zip	Code 0817				10g. Citizen Unite	of What Co	*
36	be filed within 72 hours after deeth with the Maryland ital hygiene. id other than "natural", or items 23a or 28a-f show svent, the Medical Examinational te notified at	by Funeral Director		12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:			Vas Deced Yes, spec		ispanic Orig n, Mexican Specify:	gin? (Spe i, Puerto i	ecify Yes or Ne Rican, etc.)		Race - Amer Black, White ecity: Whi	e, etc.
21215-0036	"natura	ieted	15. Decedent's Edu (Specify only highest grade		1	16a. Deced	lent's Usua kind of wo	al Occupa	ation fu <i>ring</i> most	t of workii	ng	16b. Kind o	f Business/I	ndustry
212	ed withir rgiene. er then t, the Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+ 5+	-) ]	Econo		50 1011100					earch	
Maryland	& da ta	To Be	17. Father's Name (First, Middle, Last) Ashleigh Brittai	n					18. Mothe		(First, Middle Hulber		name)	
2	nd 2 selfth ar 27 is r trau		19a. Informant's Name/Relationship (Ty Geraldine Brittain								hesda,			ip Code)
Baltimore,	00		20a. Method of Disposition  1 Durial 2 Cremation 3 R		Georg	etery, crem etown	natory or o Univer	ther place	e) J	Tanua			-	
Ę	permit. Pag Department important: if eny injury o		Date Date 20c. Location - City or Town, St. 20c. Date 20c. Location - City or Town, St. 20c. Location - City											
Ba	Den Per Per Per Per Per Per Per Per Per Per		Bhitzo	Ende	•	P	.O. I	30x 5	58007	Wash	ningtor	1, D.C.	2003.	7
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	SCL							mest, DUEA	SE	Approximate Interval Between Onset and Death UNIWIWI
	/Medical Examiner			Due to (or as a	consequen	nce of):								
Ĵ,	rate be executed thy sician and the burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a										
68760,	icate be physicia s the bur	cai		l						<u> </u>				
	at the deeth certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal de	ath 3	Ectopic pr Other (sp						Date of delice Month	very Day Year
	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions cor	stributing to death but	not resultir	ng in the un	derlying c	ause give	on in Part I.			obacco use co Yes 2 □ No		the cause of death?
Œ	The ate h page	Completed									24a. Was auto perfo 1 \( \text{Yes} \)		b. Were aut prior to co death? 1  Yes	opsy findings available ompletion of cause of
Ž.	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	ospital:		_		Othe			(Check only			
o to	Phys this aldii	은	1 Yes 2 No	1 ☐ Inpatient		Outpatient  Bb. Time of			4 LINUI		ne 5 Resi			rfy)
L C	ding A	io n	1 Natural 5 ☐ Pending	(Month, Day	Year) 28	Injury		8c. Injury Work			8d. Describe	now injury occ	currea	
	or Attending viter death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	y - At home (Specify)	e, farm, stre	M et, factory		/es 2□N		8f. Location (	Street and Nu wn, State)	mber or Rur	al Route Number,
۵	To the Hoapital or Attending within 24 hours effer death.  To the Funerel Director: After completely filled in by the fune.		29a. Certifier 15 Certifying Phys	sician: To the best of	mv knowle	dge, death	occurred.	at the tim	e, date and	place, a	nd due to the	cause(s) and	manner as :	stated.
	the Hi sin 24 the Fu	ledicai	one)	ner: On the basis of e and manner state	examination ed.	and/or inv				n occurre	at the time,			
)	To the To the Complete	Σ	29b. Signature and title of certifier	- mr	>		290	. License	31 D 2	27		29d. Date sig	ned (Month.	2007
			30. Name and address of person who co	mpleted cause of dea	ath (Item 23	Ba) (Type, F	Print)	- CWN	PC	> 5	Bentes	DA 1	ON	20814
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 05 20	32. Segistrar	's Signature	40	and i	()		(				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 11:30P<sup>M</sup> January 2, 2007 Brigida Anna Bruno /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BROOKE GROVE NURSING HOME SANDY SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2\ F Yrs. 081-12-8384-A 101 DECEMBER 5, NEW YORK Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Director MARYLAND MONTGOMERY BRINKLOW 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number r than "natural", or iteme 23a or the Medical Examinar must be 3 BRIGHTON KNOLLS COURT 20862 U.S.A. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔏 No If Yes, Give Year or Dates: 6 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. 8 BANK TELLER BANKING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Health and Mental Health and Mental H Be ANTONIO RANDAZZO MARIA GIAMBALVO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and item 27 is n LINDA JENSEN - DAUGHTER 3 BRIGHTON KNOLLS COURT, BRINKLOW, MARYLAND 20862 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: if it eny injury or o once. 1 N Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 1/6/2007 SILVER SPRING, MARYLAND 22 Name and Address of Facility 21. Signature of Funeral Service Licensee HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER Non SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIA, VASCULAR 3 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Does to for as a consequence of Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as t ettending p for use as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ HYPERTENSION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown s ueed Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an hes page 1 ☐ Yes 2X No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 ☐ Accident t Director: d in by the the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide hours after Within 24 hours and To the Funeral Dir To the Hospital 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Dey, Year) 29b. Signature land title, of certifier D0035045 JANUARY 4, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILIP HENJUM, M.D., 18109 PRINCE PHILIP DRIVE, SUITE #200, OLNEY, MARYLAND 20832 31. Date filed (Month, Day, Year) JAN 05 State 2007 Registrar

DHMH 17 Rev 1/2001

State

Registrar

Scott KELSO MD

31. Date filed (Month, Day, Year)

JAN 0 9 2007

ORIGINAL

32. Registrar's Signature

Special

			1- For State Registrar Amend #16b	State of M						ınd M	lental Hy	711	07	01557	
	Physici		Decedent's Name (First, Middle, Las.	per FH/P M. Bitt		11-09-2	200740	NM -	Journ		2. Date of De Month	Reg. No.	Year	3. Time of Death	
	/Medio Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	f Death	0/	4c. Cour	nty of Death		
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	Funeral Director		219-05-20/3	7. A	ge (In yrs. 88	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da May 1	th 19, Year) 7, 19	9. Birth Cou 18 N	place (State or Foreign ntry) 1D	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
	Many If she	tor	MD Washi	ngton	E	oonsb	oro							1 ☐ Yes 2 ☐ <b>X</b> No	
	th the	Director	10e. Street and Number				10f. Zip					10g. Citizen		ntry?	
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36	72 hours after death with the Maryland *natural', or Items 23a or 28a-f show alcal Eraninal be neithed at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Armed Forces  1 Yes 2 X  If Yes, Give Year or Dates:	?		Was Decectif Yes, spec		spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.  Specify: White			
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	)		Name and address of person who co	SEEW	death (Item	OPA+					S ME			A. O. 3.80	
	Sta	te	31. Date filed (Month, Day, Year)	Witness Co.	rar's Signa	ture	P. 48					~ (			

			For State Registrar	State of I	Maryland		artment of F rtificate of I		l Mental Hyç		007	01550
2"	巷		Decedent's Name (First, Middle,	Last)					2. Date of Dea			3. Time of Death
78	Physici /Medic		Gene Est	elle	Bake:	r			January	3 Day	2007	11:55 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution,				4b. City, Town, o				County of Death	
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п	Funeral Director		578-24-1958	1□M 2 <b>X</b> F	81	Yrs.	Months Days	Hours Mi		r, Year)	Cou	rginia
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5-0036	be filed within 72 hours after death with the Maryland that Hygiene.  Id other than "natural", or Items 23a or 28a-f show ether than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ed b	15. Decedent	Year or Date s Education	es.	16a. Deced	dent's Usual Occup	ation		16b. Kind	d of Business/Ir	ndustry
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Balt	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service	icensee					usch Fune			
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Ö	Phys rrthis eral dii	- To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of I	Injury :	R/Outpatien 28b. Time of	1 3 DOA	4 🗀 Nursing	Home 5 ☐ Resid	_		(y)
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ō	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director, tely filled in by the funeral director,											
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in the Total Director of the	Medical	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the be examiner: On the basis and manner	s of examination	rledge, death on and/or in	n occurred at the tir vestigation, in my o	ne, date and pla pinion, death o	ice, and due to the occurred at the time,	ause(s) a date and p	ind manner as s place, and due t	itated. o the cause(s)
	vithin ; o the	Mec	29b. Signature and title of sertifier		olaleu.		29c. License	e number		9d. Date	signed (Month,	Day, Year)
)	F>F0		1 Cuyo	m. C- 8	some t	~	D50	653		Janua	ary 4,	2007
•	Ω		30. Name and address of person v	who completed cause of	of death (Item 2	23a) (Type,						
	H)	0.0	Gyan C. Surana	. M.D. 585	1 Deale	- Chur	chton Ro	ad Dea	le MD 2	0751		

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 9 2007 Seems & April

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Fannie Louise Cromartie Jan. 2007 10:10 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harkord If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country)
N.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 243-88-0995 Director 56 28. 1950 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23s or 28e-f show traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Directo Maryland Aberdeen Harford 10g, Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A 201 Perrywood Ct. 21001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene, 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 Divorced It Yes, Give Year or Dates: American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 4 Librarian Social Sciences 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie Hardwick Norma Ester Pittman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1141 Whitebluff Rd. Savannah, GA 31409 Kerwin R. Cromartie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Department of Himportant: If Ite eny Injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) R.A. Ferris 1/9/2007 West Chester. PA 21. Signature of Funeral Service License 22. Name and Address of Facility 123 S. Washington St Havre de Grace, Maryland 21078 man 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shoc Physician 24 Mrs eptic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TREATO COCCA

Due to (or s a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physicien and I for use as the burial-transit The law requires that the death certificate be executed Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No W r this certificate has rai director, page 2 ROMARTI 2 No 1 Yes 2 No or Attending Physician: Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours after a To the Funarel Direct

filled

DHMH 17 Rev 1/2001

31. Date filed (Month, Day Year) 1 State

Medical

4 Homicide

(Check only one)

29b. Signature And title of certifier

ZUBAIR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHARAL

MD.

200 -32. Registrar's Signature

501

F. 19 .

29a. Certifier

🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

000063420

S. UNION AVE HAURE de GRACE, Mp. 21078

29d. Date signed (Month, Day, Year)

January, 9, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year r Physician ephus 2007 10:00 A M lildred Ann Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Care ambrida 1 Year If Under 24 Ho Dorchester Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Oct, 9 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Year 1 M 2 F 215-84-+, Director Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Experiment must be recitived as 1 1 Yes 2 No Be Completed by Funeral Director Dorchester dae 10e. Street and Number 10g. Citizen of What Country? 2 21613 US A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 12. 11. Marital Status ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: If Yes, Give Year or Dates: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Preparation Worker Restaurant 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Shirley Johnny Weeks Holland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Street Apt. B Cambridge MD. 21613 narles ephus 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State Midshore Cambridge, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY Fun exal Home, P. A. SIO Washing ton St. Cambridge, Maryland 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** A-105 54ears /Medical Due to (or as a consequence of): **Examiner** 1 mm wrode ticiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. been signed by the attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 2 No Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one, Hospital: Other: 2 200 Nursing Home 5 Residence 6 Dther (Specify) 1 🗌 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Banson HO059973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Patricia A. Johnson, 100 Bramble St., Cambridge, MD 21613 32. Regis 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** ALLIE WAYNE CHRISTOPHER, SR. 2001 1 andar /Medical . County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wiconico gional medical 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months 218-34-8094 70 JAN. 12,1936 MARYLÁND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 X No is marked other than "natural", or items 23a or 28a-f sł aumatic event, the Medical Examiner must be notifled Directo MARYLAND | DORCHESTER RHODESALE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4663 EAST NEW MARKET-RHODESDALE ROAD 21659 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 ☐ Yes 2 X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) COMMUNICATIONS Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR EOUIPMENT 10 injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev CHARLES EDWARD CHRISTOPHER, SR. MARTHA HARVEY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA A. CHRISTOPHER/WIFE O. BOX 91, RHODESDALE MD 21659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) EAST NEW MARKET CEM. 1/9/2007 EAST NEW MARKET, MD 2. Name and Address of Facility ELLER FUNERAL HOME, P. 06 MAIN STREET, EAST 21. Signature of Funeral Service Lica MD 21631 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Devo **Physician** 020 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed use as the burial-transi and Due to (or as a consequence of Box 68760 nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.0 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 performe certificate 2 X No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Lath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1740 2 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registra

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07-00003 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Georgina M. Carden State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Georgina Marie Carden Medical Examiner 0147 hrs January 1, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1800 Dry Run Road Swanton Garrett 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State of 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Maryland UNK Months Davs Hours Min Director May 25, 1961 45 M 2 **X** F Usual Residence of Decedent any 10b County 10c. City. Town or Location 10d Inside City Limits Maryland Garrett Swanton Yes 2 X No 28a-f show or items 23a or 28a-f show must be notified at once. 10e. Street and Numbe 10g. Citizen of What Country 10f. Zip Code U.S.A. 104 Misty Mountain Road 21561 Ճ Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 XXMarried 2 X No Yes If Yes, Give Year White mit Pages I and 2 should be filled within 72 hours after tranti: If item 27 is marked one or other trans. Widowed Divorced Yes 2 X No specify Specify Examiner þ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosalie Owens George Franklin Alton, Sr. 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21012 Rosalie Alton/mother 819 Bradford Avenue Arnold, Maryland 20b Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: Injury or oth Hillcrest Mem. Gardens 1/8/2007 Annapolis, Maryland Other Specify Donation 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of 147 Duke of Gloucester St., Annapolis, MD 21401 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE. ending phy: use as the b 23c. If yes, outcome of pregnancy 23d Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 🗸 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **会** 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? ✓ Yes 2 ✓ Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital 1 Other<sub>4</sub> Inpatient ER/Outpatient 3 DOA Nursing Home 5 1 V Yes 28a Date of Injury (Month Day Year) Jan 1, 2007 2Bd. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Passenger auto fixed object collision Natural Yes 2 V No Pending

Division of Vital

To the Hospital or Attending Physician: Certification: 2 🗸 Accident Investigation Location (Street and Number or Rural Route Number, City or Town, State)
 Boo Dry Run Road, Swanton, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide within 24 hours a To the Funeral I (Specify) Local Street Homicide 29a Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifier 29c License numbe 29d Date signed (Month, Day, Year) O.C.M.E. January 2, 2007 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 egistrar's Signatu State 2007 Registrar ORIGINAL OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Jan. 4, Marjorie Wilson Cashwell 2007 7:50 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Renaissance Gardens Silver Spring Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2/☐ F 041-16-8860 Yrs. 89 May 19, 1917 <u>Massachusetts</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2% No Maryland Prince George's Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Road 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Type Setter Washington Star 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wilson Edith Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie L. Marrie - Daughter 1673 Pine Knob Rd., Eldersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral Director

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Completed

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10a. State

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28af show any injury or other treumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

anding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed After this To the hours after death.

To the Funeral Director: All To the Hospital

Division of Vital Records, P.O. Box 68760,

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ospital: 1 Inpatient 2 ER/Outp	patient 3 DOA	Other: 41 Nursi	ng Home 5 ☐ Re	sidence 6 Other (S	pacify)
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DHMH 17 Rev 1/2001

State Registrar

E. S. Machado

31. Date filed (Month, Day, Year)

3110 Gracefield Rd, Silver Spring, MD

32. Registrar's Signature

		<ol> <li>Decedent's Name (First, Middle, I</li> </ol>	_ast)				2. Date of De			3. Time of Death
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/ledical aminer		la. Facility Name (If not institution, g			4b. City, Town, o	or Location of Dea		_	y of Death	
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eral	5		ATIM OFFICE	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th av. Year)	9. Birtho	place (State or Foreign
ctor		217–66–1873	5	1 Yrs.			June 25	1955	Wash	n., D.C.
	-	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
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wat be neithed at	ָ מ	10e. Street and Number	George's	upp	er Marlbo	DEO		10g. Citizen of	What Cour	
4 C	5		no Dond			20774		US		
Funeral Director	Z C	18515 Queen Anr	12. Was Decedent Ever in U	J.S. 13.			Specify Yes or No		ce - Americ	can Indian.
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2		3 Widowed 4 Divorced	If Yes, Give Year or Dates: 197.	5-77	1 ☐ Yes 2 X No	Specify:		Specia	fy: Wh	nite
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other treumatic event, tre medical Examiner of To Re Completed by Fline	2	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most or wo	orking			
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1		Edgar Eugene Co	ornelison			Shirl	ey Mille	r		
		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or F	Rural Route Numb	er, City or Town	ı, State, Zip	Code)
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or of	2	20a. Method of Disposition 1 Durial 2 Coremation 3		cemetery, crei	osition (Name of matory or other pla	сө)	Date	20c. Location	- City or To	own, State
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eny injury once.		21. Signature of Funeral Service Lic	ense		2. Name and Addre				me	
• a		Coreas	fowell		512 NW Cr				20715	5
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_		For
1	-	State
9	_	Registrar

State of Maryland / Department of Health and Mental Hygiene

			Registrar		C	ertific	ate of l	Death		Reg. N	lo.		
	J. K.W.		1. Decedent's Name (First, Middle, La					2. Date of I	Death		3. Time of Death		
	Physici /Medi		Heyward Emerso	on Canney,	Jr.				Janua	cy ,	7 2007	10:00 A M	
	Examir		4a. Facility Name (If not institution, gir	ve street and number)		4b. C	ity, Town, or	r Location of			c. County of Death	1	
4.			2819 Bosworth La	ne			Bowi	.e		1	Prince Ge	orge's	
Ç	Funeral		, ,		(In yrs. last birtho		der 1 Year	If Under 2		Birth	9. Birth	place (State or Foreign	
igi.	Director		011-18-8235	1 <b>X</b> M 2□F	86 Yrs	Mont	hs Days	Hours				York	
	p .		Usual Residence of Decedent										
	rylar	_	10a. State 10b. County		10c. City, Town o	Location						10d. Inside City Limits	
	a-f-	cto	MD Prince	George's	Во	wie						1 X Yes 2 □ No	
	or 28	Director	10e. Street and Number			10f.	Zip Code			10g. C	citizen of What Cou	intry?	
	23a (		2819 Bosworth I	ane			20	715			USA		
	dea	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	ever in U.S.	3. Was De			n? (Specify Yes or f Puerto Rican, etc.)	10-	14. Race - Amer		
9	or Itu	Ŧ	1 ☐ Never Married 2 【X Married	1 XYes 2 N	0		s 2 XNo		ruello Ricali, etc.)		Black, White	, etc.	
ဗ္ဗ	ours	l by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	II WW	I L TE	S ZLANO	Specify:			Specify: Wh	ite	
5	within 72 hours atter death with the Maryland ene. than "natural", or Itama 23e or 28e-f ahow the Mudigal Exami'ne must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. De	cedent's L	Isual Occupa	ation during most o	of working	16b.	Kind of Business/I	ndustry	
2	thin	nple	Elementary/Secondary (0-12)	College (1-4or 5	lil.	DO NO	T use retired	()	n working				
2	filed wil Hygien other th	5		4	Tec	hnica	al Wri	ter		Ae	erospace		
5	d oth	Be	17. Father's Name (First, Middle, Last	')				18. Mother's	s Name (First, Midd	le, Maide	n Sumame)		
<u>a</u>	should but Ment marked	2	Heyward E. Cann	ey, Sr.				Olive	e Gertrude	Rin	ng		
Maryland 21215-0036	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. Is marked other than "natural", or itama 23a or 28a-f ahow aumatic avant, the Mudical Examiner manke notitied at		19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Addr	ess (Street a	and Number	or Rural Route Num	ber, City	or Town, State, Z	p Code)	
Σ	D 5 ~ 3		Josephine deR. Ca	nney /spous	se 281	9 Bos	worth	Lane	Bowie,	MD.	20715		
Ze	ot He	1	20a. Method of Disposition	75 1/ 01 1	20b. Place of Di	sposition (	Name of or other place	e)	Date	20c.	Location - City or T	own, State	
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other <u>once.</u>		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	JHemoval from State	Gate of			1	/12/2007	Sil	ver Spri	na. MD	
= =	mit. partin sorts / Inju		21. Signature of Funeral Service Lice	nsee	00			s of Facility	Beall Fu				
Ö	Depa Impo any I		) Chu	n House		6512	NW Cr	ain Hw				15	
175	1		23a. Part1. Enter the disease, or com	plications that caused	the death. Do not				<del>-</del>			Approximate	
	Physician		shock, or heart failure. List only Immediate Cause (Final									Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Liver C	ancer  consequence of):								
de:	Examiner			Due 10 (01 as 2	consequence or,								
	* 4	P.	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consequence of):									
	nsit	Examiner	Cause (Disease or injury										
	al-tra	xa	that initiated events resulting in death) Last	c.  Due to (or as a	consequence of):								
9	certificate be executed ding physician and ise as the burial-transit												
68760	phy:	//Medical		_ d				·			-		
X	certi iding	/We	IF FEMALE:	23c. If yes, outcome of	of pregnancy						23d. Date of deliv		
m	death	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth : 4 Pregnant at	2 Fetal death	3 □Ectopio 5 □ Other	pregnancy				Month	Day Year	
o.	the d	Physicla	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	and or double	o 🗆 Oli lei	(Specify)						
P.0	The law requires that the death ite has been signed by the atter bage 2 should be detached for u	H.	Part II. Other significant conditions	contributing to death bu	t not resulting in th	underlyin	a cause give	en in Part I.	23e. Did	tobacco	use contribute to	he cause of death?	
Vital Records,	sign d be	d by			· ·					]Yes 2			
ö	w require been si should a	ete							1		1		
ě	e law	Completed							24a. We aut	opsy	prior to co	opsy findings available empletion of cause of	
<u> </u>		Ö							1 ☐ Yes	formed?	death?	2 □ No	
Ž	ilcian: Th certificate rector, pag	Be	25. Was case referred to nedical examiner?	Hanning.			-		Death Check only	one/			
5	Attending Physician: r death. sctor: Atter this certific by the funeral director,	၉	1 ☐ Yes 2 🕽 🗸 6		nt 2□ER/Outpa		DOA Othe	4 🗆 Nurs	ing Home 5 Me			<i>fy)</i>	
Ē	ding P h. Atter t	ü Ö	27. Manne of Death 1	28a. Date of Injun (Month, Day	Year) 28b. Timi		28c. Injury Work	at	28d. Describe	how into	ury occurred		
<u> </u>	eath or: /	cat	2 ☐ Accident investigatio			М	1 🗆 \	Yes 2 □ No	·				
Division of	l or Attan atter deat Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, farm, . (Specify)	street, fac	tory, office		28f. Location City or To	(Street a	ind Number or Rur te)	al Route Number,	
	spital or ours att seral Dis filled in												
	a Hospital or 24 hours atte e Funeral Dir letely filled in I	cal	(Check only 2 Medical Exal	nysician: To the best o	examination and/or	ath occurr	ed at the tim	e, date and printed	place, and due to the	e cause(s	s) and manner as s	itated.	
	the l	Medical		and manner stat	ed.								
	and manner stated.  29b. Signature and title of certifier						29c. Licensa				ate signed (Month,	,	
}	(5) ma	1	I draw	MUL			D23	743		Ja	n. 8, 20	07	
	30. Name and address of person who completed cause of death (Item 23a)												
	AC.		Martin Weltz, M.		Greenway	Ctr.	Dr.	Green	belt, MD.	20	770		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature								

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			1 _ State	State of Mar		tificate of			6001	01200
			Registrer  1. Decedent's Name (First, Middle, Last)		06/	lilicate of t		Reg. I 2. Date of Death	No.	3. Time of Death
п	Physicia	an			0.5			Month [	Day Year	
	/Medic		LAWRENCE E 4a. Facility Name (If not institution, give si	. 0-11-	0160	4h City Town o	r Location of Death		7 ZCO 4c. County of Deat	7 10:14 AM
	Examin	er			0,711	COLU			4.3	
			HOWARD COUNTY S. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year		8. Date of Birth	HOWAL	
	Funeral Director		1¢F1	M 2□F	Yrs.	Months Days	Hours Min.	(Month, Day, Yea	ar) Co	hplace (State or Foreign buntry)
			325 22 3738 Usual Residence of Decedent		1	L		1/14/1929		inois
	yland		10a. State 10b. County	1	10c. City, Town or Lo	cation				10d. Inside City Limits
	Mar	tor	MD Howard		Columbia	a				1 ☐ Yes 2½∑No
	r 28g	lrec	10e. Street and Number			10f. Zip Code		_	Citizen of What Co	ountry?
	h with	D E	10001 Winstream Dr	r. #403		2104	14		USA	
	be filed within 72 hours after death with the Maryland niat Hygiene. ed other than "natural", or Itams 23s or 28s-f ahow avant, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No-	14. Race - Ame Black, Whit	
9	after or its	E,	1 ☐ Never Married 2 ☐ Married	Yes 2 No	1951-	1 Tes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	iicari, dic.)		
ဋ္ဌ	iral'.	δ	3 Widowed 4 Divorced		77		Specify.		Specify: Wh	
5	72 h 'natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	tent's Usual Occup kind of work done	during most of working	16b.	Kind of Business/	Industry
21	oithin han han	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	)	DO NOT use retired	d)			
2	led v lygie her t	ပ္ပ	17. Father's Name (First, Middle, Last)	5	Offic	cer	10 Mathada Nama	(First, Middle, Maid	US Air Fo	orce
2	be fi	Be		c 1				, .,,,	en Sumame)	
3	2 should be and Mental la marked (sumatic av	٦ ا	Lucien Samuel Cliff				Mabel Jo			
Maryland 21215-0036	12 sh and lan		19a. Informant's Name/Relationship (Type Florence D. Cliffo				and Number of Rural		y or rown, State, 2 mbia, MD	21044
	permit. Pages 1 and 2 should b Deperment of Health and Menis Importent: If Itam 27 Is marked any Injury or other traumatic a ance.		20a. Method of Disposition	Tray witte	20b. Place of Dispo				Location - City or	
0	ges it of h if lts or of		1 ☐ Burial 2 【Cremation 3 ☐ Re	emoval from State	cemetery, crer	natory or other plac	ce)			
Ë	Pa tmen tent: jury		4 □ Donation 5 □ Other (Specify)		Metro Cro		1/11/		tonsville	
Baltimore,	Depermit Depermit Impor any In		21. Signature of Funeral Service License	MO MO						mily FH Inc.
	40 - 40		Gernical. K	rader			Columbia P		ott City	
		0 74	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the cause on each line	ne death. Do not ent	er the mode of dyin	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	VENTA	ICULAR	FIBRI	ILLATION			Onoot and Boam
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of);					
		_	Sequentially list conditions, b.		consequence of):	42010M	YOPATI	4		
	ed tisi	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a t	consequence or).					
_	xecut and II-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):					
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687	phys phys s the	dicai	d.							
	eat certific attending p	/We	IF FEMALE: 23	3c. If yes, outcome of	pregnancy				23d. Date of del	iven
Box	atter Ifo. L	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at tir		Ectopic pregnancy Other (specify)	/		Month	Day Year
P.O.	t the de by the a	iysi	1 Yes 2 No 9 Unknown	9□ Unknown						
		/P	Part II. Other significant conditions cont	tributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
gp	requires that een signed b hould be deta	Ď.	ADENOC ALCINON	DA OF	THE L	-UNG		1/X Yes	2 □ No 3 □ Pr	obably 4 Unknown
	w requir been si should	ete		-				24a. Was an	24h Were au	itonsy findings available
Cor	- W	-							prior to	
Recor	helav shas ige 2	mpi						autopsy performed	? death?	stopsy findings available completion of cause of
tal Recor	Page	<ul> <li>Completed by Physician/Me</li> </ul>	25. Was case referred to medical			W.	OG Plant of Doort	performed 1 ☐ Yes 2 Z	? death?	completion of cause of 2□ No
Vital Recor		Be	25. Was case referred to medical examiner?	lospital:	25 ED/Outpotion	t all post oth	26. Place of Death	performed  1 Yes 225	? death? No 1 ☐ Yes	2 □ No
of Vital Recor	Physicien: this certifice al director, p	To Be	examiner?	28a. Date of Injury	28b. Time of	I 3LI DOA	er: 4 Nursing Hom	performed 1 ☐ Yes 2 Z	death? lio 1 Yes  6 Other (Spe	2 □ No
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Division of Vital Recor	or Attending Physicien: after death. Diractor: After this certifica in by the funeral director, j	To Be	examiner?  1 Yes 2 No Ho  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only)  2 Medical Exemin	28a. Date of Injury (Month, Day )  28e. Place of Injury building, etc.  sicien: To the best of ner: On the basis of e	year) 28b. Time of Injury y - At home, farm, str (Specify) my knowledge, death xamination and/or invid.	28c. Injur Wor M 1 = cocurred at the tir vestigation, in my o	y at 2 No 2  Yes 2 No 2  me, date and place, a ppinion, death occurre	performed  1 Yes 2  Check only one)  1 Sesidence  2 Residence  3 Describe how in  3 Location (Street City or Town, St.  3 due to the cause d at the time, date a	eath? No 1 Yes  6 Other (Spe- ijury occurred  and Number or Ric are)  (s) and manner as and place, and due  Date signed (Monto	2□ No  orfy)  ural Route Number,  u stated. u to the cause(s)  h, Day, Year)
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07-00331 Jayden Thomas (	Con			<b>pe or Print i</b> ate of Maryla							egible.		
	£	- For State Registrar				ertificate d					Reg. No. 2	107	1 1156
Physicia Medical Examin		1. Decedent's Nam J	e (First, Midd ayden		s Com	modore				Date of De Month	Day Yea 12, 2007		3. Time of Death 3. 0022 hrs
	ľ	4a. Facility Name (		on, give street and n	umber)		4b. City, Town, Prince Fre				4c. County of	of Death	
Funeral		5. Social Security I	Number	6. Sex	7. Age (In yrs	last birthday)	If Under 1 Y	ear If Unde			Birth (MM/DD/YYYY	9. Birth Foreign	
Director	-	220-69- Usual Residence of		1X M 2 F	2	Y	rs.	ays flours	y IVIIII.	08/0	4/2004	Coul	ntry) MD
w any	ļ	10a. State MD	10b. County	lvert	10c. Cit	y, Town or Loca				·		T	10d. Inside City Limits 1 Yes 2 X No
aryland 8a-f she	Director	10e. Street and Nu	ımber			riinc	e Fred			ı	10g Citizen of Wh	nat Count	
th the M 23a or 2 notified		1105 C	onner					0678			USA		
death wi	Funeral	11. Marital Status  1 X Never Marri	ied 2 N	larried 12. Was De Armed F	cedent Ever in Forces?		/as Decedent of I Yes, specify Cub				No- 14 Race White		an Indian, Black,
rs after o	취	3 Widowed	harana.	vorced If Yes, Give Ye or Dates:	ar	h	Yes 2 XXI			rk dono	Specify:	B1a	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene Irant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Sec			(1-4 or 5+)		most of working l				n/a	Sille \$5/III	dustry
21215-0036 build be filed within 7 Mental Hygiene marked other than c event, the Medica	Comi	17. Father's Name		(, Last)							, Maiden Surname	)	
2121 Ild be fill Mental F marked event, t	Be	Thoma		ship (Type Print )	Commo	dore,		1	iree		Raymo		Zin Codo)
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Baltimore, sermit. Pages I an Department of He Important: If ite injury or other tr	-	4 Donation 5			1								ne 20678
Physician	$\dashv$	23a Part I Engert	he disease, o	Sewell r complications that	caused the dea								Approximate Interval
/Medical		failure. List or Immediate Cause or condition resulti	(Final disease	a Viral	syndrome								Between Onset and Death
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ecuted and - transit		events resulting in		Due to (or as	a consequence	of):							
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68760, certificate be executed nding physician and se as the burial - transi	an/M	IF FEMALE: 23b. Was decedent past 12 month	t pregnant in t	the 1 Live	birth	2 I		3 Ectopi	c pregnanc	су	23d. Date of Month	delivery Da	ay Year
30x death ne atte	Physician/Medical	1 Yes 2	No 9 Ur	denous T' =	gnant at time of nown	death 5	Other (Specify)						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	۵	Part II. Other sign	iificant condi	tions contributing	to death but no	t resulting in the	e underlying caus	e given in Pa	art I.		tobacco use contr		ne cause of death?  ably 4 Unknown
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the star death  "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed									24a Wa	as an 24b V	Were auto	opsy findings available empletion of cause of
Reco The lav	Comp									per	formed?	death?	
of Vital Recing Physician: The L	o Be	25. Was case refe examiner? 1 ✓ Yes	rred to medic	Hospital: 1	Inpatient 2	✓ ER/Outpatie		Other <sub>4</sub>	_	ly one) Home 5	Residence 6	Other	
n of Vit ding Physic After this funeral dire	-1	27. Manner of Dea	ath	28a. Dat (Mon	e of Injury th, Day,Year)	28b. Time o	of Injury 28c. In	Yes 2		8d, Describ	e how injury occurr	ed	
VISIO or Atten fer death firector: in by the	Certification:	2 Accident 3 Suicide	Inve	estigation	ace of Injury - At	home, farm, st	reet, factory, offic					er or Rura	al Route Number, City
Div ospital o hours af neral D	Cert	4 Homicide 29a Certifier	dete	ermined (Specif)						or Town			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only 1 one) 2		Physician: To the be aminer:On the basis and manner	s of examination								
FSFS	ž	29b. Signature and	d title of certif					ense number C.M.E.			29d. Date sign		
		30. Name and add	dress of perso	n who completed ca	use of death (Ite	em 23a)		♥. 1¥1. <b>L</b> .			January 12	., 2007	
		Ana Rubio		sistant Medical	Examiner Gistrar's Sign		Street, Baltin	more, MD	21201				
St Regist	ate trar	31. Date filed (Moi	JAN 1	6 2007	CALLAR.	J. 19	carles						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Albert Earl DAVIS Sr. 2007 January 10, 7:30 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington NMS Healthcare Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F 417-28-0274 84 Yrs Director Aug. Alabama Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23a or 28e-f show the Medical Exandinar must be notified at 1 TYes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1141 Woodland Way 21742 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No white ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry public school other than Elementary/Secondary (0-12) College (1-4or 5+) educator system 12 6 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Menial Hy Importent: If item 27 is marked otheny any injury or other traumatic event 17. Father's Name (First, Middle, Last) Albert Guthrie Davis Hattie Lucille McCloud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary J. Davis - wife 1141 Woodland Way, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1/13/07 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME Ε. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op-ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal peath 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 3 Probably 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice Be 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Tope, Print) 9414-C 31. Date liled (Month, Day, Year)

JAN 12 2007 32 Registrar's Signature State Registrar

			riease i	State of Manuar				-	_	•
			1 _ State	State of Marylar	-	artment of H rtificate of l			711117	01569
			Registrar  1. Decedent's Name (First, Middle, Last,	)	Oei	lilicate of t	Jeaur	2. Date of Deatl	ng. No:	3. Time of Death
	Physici		Mildred Donnell					Month	Day Year	
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	Januar	y 4,2007	
	LXAIIII	ici	Fort Washington			Fort Wa	ashingto	on	Prince	George
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
	Director		210-20-1054	M 25XF 77	Yrs.			April	11,1929	Tennessee
	land		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	to	Maryland Charl	es I	ndian	Head				1 ☐ Yes 2 🙀 No
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (	Country?
	th wit	alD	3265 Green Mead	ows Drive		2064	0		U.S.A.	
	tems terms	Inel	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
36	s afte	by Funeral	1 Never Married 2 Married 3	1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates:		1 □ Yes 2⁄□ No	Specify:		Specify: V	<i>N</i> hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show ta Madrell Examiner mat be notified at	edt	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busines	s/Industry
215	hin 72	pie	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	furing most of worki )	ng		·
	er the	Completed	12		Home	maker			Her Hon	ne
nd	tal Hydral Hydral avent	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
Z	should be filed with nd Mental Hygiene. i marked other thau umatic avent, ILE I	스	Charles J. Cron		10) 11 11			A. Rou		7.0.11
Maryland	C1 40 70 40		19a. Informant's Name/Relationship (Ty Bernice A. Beal						City or Town, State,	
ā,	Health tem 27 other tr		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of	1 0	Date 2	Oc. Location - City o	r Town State
9	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	etropo	natory or other piac. litan Fi	"Jan uneral <sup>9</sup>	2007 Service	Alexand	dria, Va.
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any Injury or other tr once.		21. Signature of Funeral Service Licens		22	Name and Address	s of Facility			
œ.	Pe G		Washall	M0066	0 1	William 270 Haw	thorne F	d In	dian Hea	20640 ad, Md.
			23a. Part1. Enter the discuse, or compleshock, or head to tre. List only of	ications that caused the deal ne cause on each line.	h. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition			cancer				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	juence of):					
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	juence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
3760,	~ > w	icai		d						
x 68	The law requires that the death certifica ale has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregn						
Вох	attend for us	ian	in the past 12 months?	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
P.O.	y the diched	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ioaiii 5	JOTHER (Specify)				
	res that igned b be deta	by Pr	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	w require: been sig should be	ed b						1 □ Ye	s 2 <b>0</b> 00 3□f	Probably 4 Unknown
000	e taw requ has been je 2 shouli	Completed						24a. Was an		autopsy findings available completion of cause of
Ä		E O						l perform	ed? death?	
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only one	)	
of \	S S D	6	1 ☐ Yes 2 No 27. Manner of Death	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier		4   Nursing Hor		nce 6 Other (Sp	ecify)
		tion	1 Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	Work	at ? ′es 2 □ No	28d. Describe ho	w injury occurred	
Division	or Attendated after death Director:	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - At h					eet and Number or F	Rura / Route Number,
ă	s after	Cert	4  Homicide determined	building, etc. (Special	<b>'y</b> )			City or Town,	State)	
	hour hour uners		29a. Certifier 1 Certifying Physical Certifying Physical Exami	sician: To the best of my kno ner: On the basis of examina	wiedge, deat	occurred at the tim	e, date and place, a	and due to the ca	use(s) and manner a	as stated.
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	one)	and manner stated.						
	To To Con	4	29b. Signature and title of certifier	nu h		29c. License			d. Date signed (Mor	
(			30. Name and address of person who co	ompleted pause of doorb (the	n 23a\ /Tune	Print)	7 000		المراسات ال	7,007
1	BID		1 11	ANNER MO 1	1701 L	winston	Road F	at was	Jonuary Hington,	MAMILAND
	Sta		31. Date filed (Month, Day, Year)	32. Signatrar's Signa	ature	Cast 1				
	Reaisti	rar	JAN 0 9 2	007 Malue	Ar D	SELET				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar		State	or iviary	/land / De <i>C</i>	partmer e <i>rtifica</i> :			Mental H	ygiene Reg. No		01570	
Physic	1. Decedent's Name (First, Middle, Last)  hysician								2. Date of I Month	2. Date of Death 2 3 1im				
/Med	ical	Mabel Dickerson						4b. City, Town, or Location of Death			ry 1	1, 2007 10:3		
Exami	ner	3160 GRACEF					4b. Oity		VER SPRIN			MONTGOME		
Funeral	Г	5. Social Security Number	6. 5			n yrs. last birthda	Months	er 1 Year	If Under 24 Hrs Hours Min	8. 8 Date of F	Birth Day, Year)	9 Rin	hplace (State or Foreign untry)	
Director		436-28-6432 Usual Residence of Decede				85 Yrs.				OCTOBE			JISIANA	
re Maryland Ba-f show hiffed at		10a. State 10b. C			10	Oc. City, Town or	Location			-			10d. Inside City Limits	
	Director	MARYLAND M	MARYLAND MONTGOMERY				SILVER SPRING				1 ☐ Yes 2 ☑ No			
with the	D I	10e. Street and Number 3160 GRACEFIELD ROAD, #1432						10f. Zip Code 20904			10g. Cit	tizen of What Co	,	
death ms 23	Funeral	11. Marital Status	EFIELL	12. Was Dec	cedent Eve	er in U.S. 1	3. Was Dec	edent of Hi	spanic Origin? ( n, Mexican, Pue	Specify Yes or I	No-	14. Race - Ame	rican Indian,	
urs after or all; or Iter	2	3 ☐ Widowed 4 ☐ Div		Armed F 1 ☐ Yes If Yes, G Year or I	2 X No live			ecity Cuba 2⊠ No		no Rican, etc.)	:	Black, White	e, etc. WHITE	
s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Sa or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. De (Specify only Elementary/Secondary (0	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-								16b. Kind of Business/Industry			
			iddle Lee	. 4		ADMI	NISTRAT	IVE AS	SISTANT	ıma (First Midd	lle Maider	OFFICE	<u> </u>	
d be fi ental H ked ot c evel	To Be	W .					AMY LANI					Middle, Maiden Surname) DRY		
2 should be filed and Mental Hygi Is marked other aumatic event, <u>t</u>	F		19a. Informant's Name/Relationship (Type. Print)			19b. M	19b. Mailing Address (Street and Number or Rural					al Route Number, City or Town, State, Zip Code)		
and 2 lealth a m 27 Is		THOMAS G. DIC	KERSON	- SON					ORSE LANE	, GREAT I	<del></del>	VIRGINIA		
ages 1 nt of H t: If ite / or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem				•	rematory or	other plac	· i			ocation - City or		
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trav		4 □ Donation 5 □ Of				GATE OF	22. Name a	and Addres	s of Facility	/2007 HOME TA		LVER SPRII	NG, MARYLAND	
		HINES-RINALDI FUNERAL HOME, INC.  11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904												
Physician	ı	23a. Part1. Enter the Hisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fall re. List only one cause on each line.  Immediate Cause (Final disease or condition  CHRONIC OBSTRUCTIVE PULMONARY DISEASE												
/Medical Examiner		resulting in death)  a. CHRONIC OBSTRUCTIVE FULL FOUNTAIN DISEASE  Due to (or as a consequence of):  ALZHEIMERS DISEASE												
nsit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  c.											
ificate be executed g physician and as the burial-transit		Due to (or as a consequence of):												
	Medical													
w requires that the death certif been signed by the attending should be detached for use a	hvsician/M	23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 \overline{\text{SNo}} \text{ No} \text{ 9}   Unknown    23c. If yes, outcome pf pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify)   9   Unknown							-	23d. Date of delivery  Month Day Year				
requires that the een signed by the	0								use contribute to	se contribute to the cause of death?				
equires en sigr	yd be								☐ Yes 2	Yes 2 No 3 No Probably 4 Unknown				
has ye 2	Completed							24a. W - au pe 1∐ Ye	itopsy erformed?	psy prior to completion of cause of				
	Re	25. Was case referred to r	25. Was case referred to medical examiner?											
this al dil	I.	- X			Inpatient te of Injury	2 ER/Outpa		,	4 Li Nursing		tome 5 ☑ Residence 6 ☐Other (Specify)  28d. Describe how injury occurred			
	Cortification.	1 Natural   5 Pending   (Month, Day Year)   Injury   Work?   1 Yes 2 No												
in the property of	Cortifi													
te Hospital of 24 hours are Funeral E	Modical	29a. Certifier 1 General Control of the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
To the within 2 To the comple	Mo									29d. D	ld. Date signed (Month, Day, Year)			
3		Loveen Luthumana, MD D59524 JANU							NUARY 2, 2007					
		30. Name and address of						प्राप्त सम	CDDTMC A	MADVI AND '	2000			
S	state	LOVEEN J. PUT	Year)	320	egistrar'	s Signature	72		DIVING I	WITHUN .	20704			
Regis		I IAN	082	107   1		. K 1	Sac.	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrarAMEND#8perFH1/5/07,BMW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARILYN JOYCE DUNSMORE JANUARY 1, 2007 7:25 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RENAISSANCE GARDENS - RIDERWOOD NURSING HOME SILVER SPRING MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 30–1925 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 🛛 F 81 504-20-2595 IOWA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 614 NORTH CLIFF DRIVE 20850 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ॲ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 Nidowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED DIETICIAN MANORCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EMILY FILARSKI ALBERT HOLMBERG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK DUNSMORE - SON 12060 OLD FREDERICK ROAD, MARRIOTTSVILLE, MARYLAND 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/10/2007 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CREMATORY BRENTWOOD, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 MONTH METASTATIC CARCINOMA disease or condition resulting in death) 6 MONTHS of delivery Dav Year bute to the cause of death? 3 ☐ Probably 4 ☑ Unknown Vere autopsy findings available rior to completion of cause of eath?

☐ Yes 2☐ No

Physician /Medical **Examiner** 

Department of Healt Important: if item 2 any Injury or other once.

**Physician** 

Examiner

Funeral

Director

a or 28a-f show t be notified at

ns 23a must b

"natural", or Item edical Examiner r

nd 2 should be filed Ith and Mental Hygis 27 is marked other r traumatic event, II

Pages 1 and 2 ment of Health

Director

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, nding physician use as the buria ed by the a detached f

Attending Physician:

al or Attendi after death.

page funeral filled in by the To the Hospital of within 24 hours af To the Funeral D completely filled i

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Loveen

05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Physician/Medical Examiner		WEIGHT LOSS							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):							
	resulting in death) Last	Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (∑ No 9 □ Unknown		23d. Date of delivery Month Day Yea						
by	Part II. Other significant conditions co		cco use contribute to the cause of deatl						
Completed			performed? dea	re autopsy findings ava ir to completion of cause th? Yes 2 No					
Be	25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)						
10	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Ho	ome 5 Residence 6 Other	(Specify)					
	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)   28b. Time of Injury   28c. Injury at Work?   1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number City or Town, State)						
dical (	29a. Certifier  (Check only one)  29a. Certifier  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								

Thumang, MD

Registrar's Signature

LOVEEN J. PUTHUMANA, M.D., 3110 GRACEFIELD ROAD, SILVER SPRING, MARYLAND 20904

DHMH 17 Rev 1/2001

State

Registrar

29c. License number

D59524

29d. Date signed (Month, Day, Year)

JANUARY 2, 2007

			1 - For State Registrar	State of Marylan			lealth and	Re	g. No. UU/	01572		
. *	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death		
8	/Medic		Elizabeth H. Duff			4b. City, Town, o	r Location of Dog		5, 2007 4c. County of Deat	0200 AM		
1	Examin	er	Laurelwood Care C				iton	ati.	Cecil			
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	iast birthday)	If Under 1 Year	II Under 24 Hr	s. 8. Date of Birth		hplace (State or Foreign		
36	Director		222-03-0214 1 M 2 K 92 Yrs. Months Days Hours Min. Nov. 24, 1914 Pennsylvania Usual Residence of Decedent									
Maryland 21215-0036	shov	5	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No		
	28a-l	ect	Maryland Cec	u	Kisi	ng Sun	<del></del>	10	g. Citizen of What Co			
	3a or	Funeral Director	125 Pierce Road		21911		,,	USA	unity:			
	ms 2	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?			ispanic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Race - Ame	14. Race - American Indian, Black, White, etc.  Specify: White		
	be filed within 72 hours after death with the Marylan ital Hygiene. Adother then "natural", or itema 23a or 28a-f show event, the Madical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 Yes, Give Year or Dates:	]Yes 2.7X(No ∕es, Give 1		Specify:	no Hican, etc.)	Specify			
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	within ene. then "	ld III	Elementary/Secondary (0-12)	College (1-4or 5+)	Cleri	DO NOT use retired	1)		Dotail C			
d 2	e filed within al Hygiene. I other then '		17. Father's Name (First, Middle, Last)	2	cell	2	18. Mother's Na	ame (First, Middle, M	Retail G	rocer		
and	id be ental ked o	To Be								laiden Sumamey		
ary	should be and Menta marked umatic ev	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailin	g Address (Street			City or Town, State, Z	ip Code)		
	and 2 alth a 127 is		Stephanie Barbour	/Great Niece_	125	Pierce R	Road, Ri	sing Sun,	MD 21911			
ore,	of He of He litem		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place			Oc. Location - City or	Town, State		
Ĕ	Pag nent ant: if		1.  Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval from State		ingham C	1	0-2007	Colora, Ma	ruland		
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: if Item 27 is marked eny injury or other treumatic e once.		21. Signature of Funeral Service Licens		R. 22	Name and Addres	ss of Facility Funera	l Home, P.	A. , MD 21911			
*	Physician /Medical		23a. Part : Enter the disease, or complishook, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	icatic s hat caused the death ne c u e on each line. a.	n. Do not ente	er the mode of dyin	g, such as cardia	ac or respiratory arres	st,	Approximate Interval Between Onset and Death		
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Box 68	h certifica ending ph use es th		IF FEMALE: 23b. Was decedent pregnant		23d. Date of delivery							
of Vital Records, P.O. Physician: The law requires that the d	that the death certific ed by the attending p detached for use es	Physician/Med								Month Day Ƴear		
	w requires that been signed should be det	þ								cco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably ☐Unknown		
	Physician: The law r this certificate has be ral director, page 2 sh	Completed						24a. Was an autopsy performe	prior to c death?	opsy lindings available ompletion of cause of		
	ician certifi ector	Be	25. Was case referred to medical examiner?	Joan tali		lou		ath Check only one				
	Phys this ral dir	2							me 5 Residence 6 Other (Specify)			
	ding Afte fune	atlon	1 Natural 5 Pending 2 Accident investigation	rat (? Yes 2∐No	28d. Describe how injury occurred							
DIVIS	2 ± ± €	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
# Hospit	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (										
	To th within To th comp	Me	9b. Signature and title of cellular 29d. Disparation 29d.							Date signed (Month, Day, Year)		
			►	D54073					05 Jan 07			
			30. N me and address of lers vivo a	ompleted cause of death (Item	23а) (Туре, І	Print)	(5/)					
	0		HUEN JUNE 1	m BI	$\mathcal{I}$	sum tus	(7)	NEW LAS	NE DE	19720		

			1 - State of Mar Registrer		ent of Health and Mate of Death	/	$I \cup I \cup I$	01573
			Decedent's Name (First, Middle, Last)			Reg. No 2. Date of Death	).	3. Time of Death
	Physici		LAWRENCE R. EASTI	ERLING		JAN 3	y Year	12:30pM
de la	/Medic Examin		4a. Facility Name (If not institution, give street and number)		ity, Town, or Location of Death		. County of Death	
		•	PRINCE GEORGES HOSP	ITAL C	HEVERLY	Pr	RINCE G	EORG ES
	Funeral		5. Social Security Number 6. Sex, 7. Age (	In yrs. last birthday) If Un	der 1 Year   II Under 24 Hrs.	8. Date of Birth (Month, Day, Year,	9. Birthr	place (State or Foreign
	Director		238-24-8859 XM 20F	84 Yrs.	la baya tiouis mai.	10 18 19	722	"NC
	and *		Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, Town or Location			1	0d. Inside City Limits
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	28a-	Director	10e. Street and Number	CAPITOL 1-	Zip Code	100 Ci	itizen of What Cour	
	with Sa or				2074	_	CA	itty:
	ms 2%	iera	12.53 BOOKER TERM 11. Marital Status 12. Was Decedent Ev				14. Race - Americ	ean Indian,
ထ	or ite	Fur	1 Never Married 2 Married 1 Yes 2 No		cedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
8	ral', c	i by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 L Yes	S 20 No Specify:		Specify: BLA	ACK.
21215-0036	illed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ith, it a Madical Examinat must be notified at	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's U (Give kind of	work done during most of work	16b. h	Kind of Business/Inc	dustry
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ē,	Hea Hea Heam		20a. Method of Disposition	20b. Place of Disposition //	Name of		ocation - City or To	
9	Pages nent of int: if it iry or o		1 Rurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	FT. LINCOL	1 .	1/2007 131	PIFAITIMO	on mo
Baltimore,	그림문을 .		21. Signature of Funeral Service I Pensee	22. Name	and Address of Facility No	SITNE	RAL H	4me
Ö	Depa Impo any ir		Class mill	504	10-1744.ST	IE HY	45H DC	20017
			239 Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause op each line.	e death. Do not enter the m	node of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
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	/Medical		resulting in death)	consequence of):	1			
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	p tis	lner	Sequentially list conditions, Due to (or as a cause. Enter Underlying Cause (Disease or injury	consequence (ft):	1 40			
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Вох	nding nding use a	Ž.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of				23d. Date of delive	arv
ă	The law requires thet the death certifi sie hes been signed by the attending age 2 should be detached for use as	Physician/M	in the past 12 months?		c pregnancy (specify)		Month	Day Year
o.	t the by the	hys	9 Unknown 9Unknown					
ຜົ	as the gned	by P	Part II. Other significant conditions contributing to death but	not resulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
Vital Records,	w require been sign	ed				1 ☐ Yes 2	No 3□ Prob	ably 4 □Unknown
ecc	e faw r hes be je 2 sh	ple				24a. Was an autopsy	24b. Were auto	psy findings available
<u> </u>		Completed				performed?	death?	npletion of cause of 2□ No
/ita	ician: 1 certifice rector, p	Be	25. Was case referred to medical examiner?		26, Place of Deat	Check only one		
	Physician: r this certific ral director,	2	1 ☐ Yes 2 No Hospital: 1 Inpatient			me 5 Residence	6 ☐Other (Specify	v)
Ĕ	Afte Lune	lon	27. Map fer of Death  1 Natural 5 □ Pending  28a. Pate of Injury (Month, Day Y		Work?	28d. Describe how inju	ry occurred	
isi		Icat		M At home laws street less	1 ☐ Yes 2 ☐ No	201 Lagation (Street )	and Alicenter and O	
Division of	i or Attend efter death Diractor: I in by the f	Certification;	4 Homicide determined building, etc.	- At home, larm, street, lact (Specify)	tory, office	281. Location (Street al City or Town, State	e)	i Houte Number,
_	Hospital or 24 hours effe Funeral Dir stely filled in		29a. Certifier 12 Certifying Physicien: To the best of	my knowledge, death occurr	ed at the time, date and place	and due to the cause(s	and manner as s	ated
	To the Hospital or Attentwithin 24 hours effer deatl To the Funeral Director: completely filled in by the	edical	(Check only and manner state	xamination and/or investigat	ion, in my opinion, death occurr	ed at the time, date an	d place, and due to	the cause(s)
	To the within 2 STo the complet	ž	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month,	Day, Year)
)	XC		Vilane		030318	- 11	13/0	7
	KY		30. Name and addless of person who completed cause of dea	th (Item 23a) (Type, Print)	1-13-1	76 ,	-/-	-
	(0)		31. Date liled (Month, Day, Year)   32. Registrar's	3001 MOSP	OITAL DR C	11KVRRI	( IND	20183
	Sta Registr		JAN 1 0 2007 Range 19:	s Signature		,		

REPLACETY DE CEPTINE IN Black Indelible Ink. Ensure All Copies Are Legible. Transito De Jesus Rodriguez Escobar 2007 01574 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical Examiner Transito De Jesus Rodriguez Escobar 1619 hrs January 4, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 651 Romancoke Road Stevensville Queen Anne's 5. Social Security Number If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** oreign **El Salvador** Months Days 213-61-0072 Hours Director 45 1 X M 2 F August 14,1961 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County 1 Yes 2 X No is 23a or 28a-f show e notified at once. or 28a-f show MD Prince George's Hyattsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8125 14th Avenue, Apt. #001 20783 El Salvador Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Pages 1 and 2 should be filed within 72 hours after death wit ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items 3 or other traumatic event, the Medical Examiner must be a If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. Married Never Married 2 X No El Salvadorean Yes Specify: White If Yes, Give Year 1 X Yes 2 No specify 3 Widowed Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 0 Construction Worker Homes Building Compl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Santiago Escobar Ibanes' Martha Rodriguez Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 19a. Informant's Name/Relationship (Type, Print) 8125 14th Avenue, Apt. #001, Hyattsville, MD Mirna Saldana - Daughter 20c. Location - City or Town, State
Santa Ana, El Salvador 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Cementerio Aldea 1 X Burial 2 Cremation 3 Removal from State 01/12/2007 portant: 4 Donation 5 Other Specify: Bolanos 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, MD 21. Signature of Funeral Service Licensee Nancy A. Percentie, per DVR 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical Item 21 per FH, g882,08/14/08dhb UNPENDED **AMENDED** attending physician or use as the burial -The law requires that the death certificate be Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23h. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Por 9 Unknown med by the setached for Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ≥ σ Yes 2 V No 3 Probably 4 Unknown Completed Records, After this certificate has been s funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 25. Was case referred to medical or Attending Physician: 26.Place of Death (Check only one) Division of Vital Be Hospital: Other<sub>4</sub> Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes 28a. Date of Injury (Month Day,Yeer) Jan 4, 2007 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification Subject fell 1 1600 hrs Natural 1 ✓ Yes 2 No Pending after death. Funeral Director: the 2 🗸 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) 651 Romancoke Road, Stevensville, MD (Specify) Construction Site Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the F Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 manner stated 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year)

OCME

State

Registrar

Susan Hogan MD.

AUG

31. Date filed (Mo

DHMH 17 Rev 1/2001 **OCME 2006** 

M

DR

Assistant Medical Examiner

npleted cause of death (Item 23a)

strar's Signat

RIPPLE

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 5, 2007

	1		For State Registrar		f Marylar		artment of F	lealth and N Death		iene	7	01575
П	Physici	an	Decedent's Name (First, Mid  TMET DA		No				Date of Death     Month	Day	Year	3. Time of Death
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	Exami	er	Prince George		,			r Location of Death		4c. County		
	Funera		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday	Chever	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Prince		
	Director		129-12-5934	1 ☐ M 2 🛣 F	88	Yrs.	Months Days	Hours Min.	Feb. 22	, 1918	New	olace (State or Foreign ntry) 7 York
	and		Usual Residence of Decedent  10a. State 10b. Coun	tv	10c Ci	ty, Town or L	ncation					
	Maryl f sho	5	DC	.,	100.01	Washir					1	10d. Inside City Limits 1X Yes 2 □ No
	1 the	rect	10e. Street and Number			Wasiili	10f. Zip Code		10	g. Citizen of V	/hat Cour	
	h with	O I	162 35th St.	N.E.				019		USA	viiat Coul	my:
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health end Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28a-f show or other treumstic event, the Marical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Dece Armed Fo	edent Ever in L	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race		can Indian,
36	s after, or it	by Fu	1 Never Married 2 Ma	arned 1 Tes	2 X No		1 ☐ Yes 21X No	an, mexican, Puerto  Specify:	Hican, etc.)		k, White,	
Ö	hours ture!	d b	3 ☑ Widowed 4 ☐ Divorce	ed Year or D	ates:					Specify	В	lack
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5	e filed at Hygid other vent, I	BeC	17. Father's Name (First, Middle	9, Last)		FILLEC	ily reison	18. Mother's Name				. <u>y</u>
<u> a</u>	should be fand Mental Parameter of	To E	Herbert Isaac	s				Imelda	I. Runne	11s		
Maryland 21215-0036	2 sho end ie ma		19a. Informant's Name/Relation	nship (Type, Print)		19b. Maili	ng Address (Street	and Number or Rura	al Route Number,	City or Town,	State, Zip	Code)
_	and fealth m 27		Joyce E. Bulga	r/ Friend		Mitc	Spriggs hellvill	e, $Md$ . 20	721			
altimore,	Pages 1 nent of H ant: if ite ury or ot		20a. Method of Disposition 1   Burial 2 □ Cremation	3 Removat from	State 20b. F	Place of Dispo cemetery, crei	osition (Name of matory or other place	(e)	Date 2	Oc. Location -	City or To	wn, State
Ħ	it. Pa ritmen ritant: njury		4 Donation 5 Other		Ha		Memoria1		-2007 1	Landove	r, M	d.
Ba	permit. Pages Department of Important: If I eny Injury or once.		21. Signature of Funeral Service	a Licensee	1	22 N	2. Name and Address larshall	ss of Facility S Funeral	Home, In	nc.		
8760,	The law requires that the death certificate be executed by Walking by the eltending physicien and be some signed by the eltending physicien and be some some signed by the eltending physicien and be some some some some some some some som	dical Examiner	23a. Pab. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ACUTE Due to (  Due to (  c.	acit inte.	BARA  Juence of):  HY  Juence of):	er the mode of dyin	L HEMO	or respiratory arre	st,	, 0 .	20011 Approximate Interval Between Onset and Death
.O. Box 6	at the death certific by the ettending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		inth 2 ☐ Feta ant at time of d	I death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ory Day Year
ທ໌ ໄ	res that igned b be deta		Part II. Other significant condit		ath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	icco use contri	bute to th	e cause of death?
Hecords,	w require been sig should b	Completed by	ADVANCED AG	,					1 ☐ Yes	2 <b>X</b> No ∶	3 🗌 Proba	ably 4 □Unknown
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Vital	ilcien: Th certificete rector, pag	Be (	25. Was case referred to medic examiner?					26. Place of Death			⊒ Yes	2L NO
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		Certification;	27. Manner of Death 1 X Naturat 5 ☐ Pend		of Injury h, Day Year)	28b. Time of Injury	Work		28d. Describe how	injury occurre	d	
DIVISION		Icat	3 ☐ Suicide 6 ☐ Could		of laine. At he			Yes 2 □No				
2	2 2 2 2	erti	4 Homicide deten	mined 288. Place buildin	ig, etc. (Specify	y)	eet, factory, office	1	28f. Location (Stre City or Town,	et and Numbe. State)	r or Rural	Route Number,
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the I Examiner: On the ba and mann	SIS OF EXAMINA	wledge, death tion and/or inv	n occurred at the time restigation, in my op	e, date and place, a pinion, death occurre	and due to the cau ed at the time, date	se(s) and man e and place, ar	ner as stand due to	ated. the cause(s)
	withi To the	Σ	29b. Signature and ritte of certific	er /	1		29c. License		290	1. Date signed	(Month, D	Jay, Year)
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	30		30. Name and address of person				Print)		CHEVERLY		/	
	<b>9</b> /)		K. MICHAEL F. 31. Date filed (Month, Day, Year	1GARD 32 BG	300/		PITAL D	K (	HEVERLY	MD	20%	185
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State of Maryland / Department of Health and Mental Hygien@ [] [] 7 For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year 2007 Dorothy Michaelson Eckels 5, Jan. 6:29 Рм /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9330 Woodland Road Charles Pomfret 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of 8irth (Month, Day, Year) Jan. 6, 1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 ☐ M 2 🔀 F 77 Director Yrs Minnésota 470-26-2339 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show t of Health and Mental Hygiene. If fiem 27 is marked other then "naturel", or items 23s or 28s-f ehov or other treumatic event, the Mcdical Examinar must be notified at 1 ☐ Yes 2 💆 No Funeral Director Maryland Charles Pomfret 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9330 Woodland Road 20675 US filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other ery liquy or other treumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roy Michaelson Ethel Jane Nealv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Megan Baker - Daughter 4941 Chestnut Street, Shadyside, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 1-8-2007 Waldorf, MD 21. Signature of Funeral Service Licensee  $\sim M01246$ 22. Name and Address of Facility 3035 Old Washington Road Wilson Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each liga. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine efter death. I Director: After this certificele has been signed by the ettending physicien and d in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 (No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) cumpletely filled in by determined 4 Homicide within 24 hours e tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 0 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			for State	Pleas			nd / Dep	artment of h	Health and	-		_	01577
			Registrar AVE		1/8/07,BMW,	MbCb	Ce	rtificate of	Death		Rag. N	6.001	01311
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	Examir	ner	4a. Facility Name (I	f not institution,	give street and nun	nber)		4b. City, Town, o	or Location of De	ath	4	c. County of Death	1
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	Funeral		5. Social Security N		3. Sex 1 □ M 212 F	7. Age (In yrs.		If Under 1 Year   Months Days	If Under 24 H Hours Mi	in. (Month, D	ay, Year		place (State or Foreign intry)
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Baltimore, Maryland 21215-0036	os 1 enc of Heelt item 2	1 8	20a. Method of Disp	position			Place of Disc	osition (Name of ematory or other pla		Date	20c. l	ocation - City or T	own, State
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87	death certificate ettending physical for use as the f				d								
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sio	eath. or: A	cati	2 Accident	investiga	tion				Yes 2 ☐ No				
Division of Vital Records,	or Attending Physician: ifter death. Director: After this certifice in by the funeral director, p	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	200. Place	of Injury - At hing, etc. (Specif	ome, larm, s fy)	treet, lactory, office		281. Location City or To	(Street a	nd Number or Rur le)	al Route Number,
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	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: Atter th completely filled in by the funeral	edicai	29a. Certifier (Check only one)	2 Madical E	Physician: To the kaminer: On the ba and mann	isis of examina	owledge, dea ation and/or i	th occurred at the travestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(: ), date ar	s) and manner as and place, and due t	stated. to the cause(s)
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	20		30. Name and addr	ess of narenn w	ho completed care	a of death (Item	TI 23a) (Tues	Print)	0 5 4			1/03	107
			Heather L						nev. MD	20832			
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			Please	State of Ma					ind Mental I		_	
		•	For State Registrar		w. y			of Death		Reg. N	2011	0   5   7   8
	Dharaisi		1. Decedent's Name (First, Middle, La	ist)					2. Date of Month		Day Year	3. Time of Death
M. gib.ggi	Physicia /Medic		Amanda				Fry		Janu	ary 3	3, 2007	4:50 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, gi					vn, or Location of		4	4c. County of Dea	
-			18917 Lindenhous		ie (In vrs. I	ast birthday)	If Under 1 Y	hersburg Gear   If Under 2	24 Hrs. 8 Date of	Birth	Montgome 9. Bird	
, Ac	Funeral Director		-	1 □ M 2 🔀 F	34	Yrs.		ays Hours	Min. (Month	Day, Yea	1972 Pue	hplace (State or Foreign buntry) erto Rico
da-	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c Cit	, Town or Lo	cation					10d. Inside City Limits
	faryla shov	ō			Toc. Oity							1 X Yes 2 No
	the 1 28a-1 notifi	Director	MD Montgor  10e. Street and Number	nery		(-	aither			10g. (	Citizen of What Co	puntry?
	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		18917 Lindenhou	ise Road				20879			United	States
	ems ?	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.1	Was Deceden	t of Hispanic Orig Cuban, Mexican	gin? (Specify Yes o , Puerto Rican, etc.	No-	14. Race - Ame Black, Whit	
36	s afte	by Fu	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give	No		1 ☐ Yes 2 ☐				Specify:	White
Ö	hour tural	ed b	15. Decedent's E	Year or Dates:		16a. Dece	dent's Usual C	ecupation		16b.	Kind of Business	Industry
215	nin 72 In "ne Medic	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or l	5+)	(Give life.	kind of work o DO NOT use r	done during most etired)	of working	I		,
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nd	be filk	Be	17. Father's Name (First, Middle, Las	t)					r's Name <i>(First, Mid</i>		,	
<u>\</u>	hould d Mer marke matic	ဥ	Edmund M. Fry  19a. Informant's Name/Relationship	(Time Print)		19h Mailir	na Addross (S		ndra J. J er or Rural Route Ni			Zin Cadal
Baltimore, Maryland 21215-0036	nd 2 slith an Ith an 27 is r		Sandra J. Fry / N	, ,,					Road, Gai			
re,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	_	20b. P	lace of Dispo	sition (Name	of er place)	Date	20c.	Location - City or	Town, State
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 【XCremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec		Me	ropol remat	nsition (Name of matory or othe itan ory	J.	anuary 4 2007	A	lexandri:	a, Virginia
Salt	epartr epartr porta y inj		21. Signature of Euneral Service Lice			22	2. Name and A	ddress of Facility	DeVol F	unera	1 Home,	10 East
_	\$0 <b>5</b> 8 8	Н	1.0.	Ervec	-1.11				-		.g, MD 20	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	-						ry arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Svain Due to (or as			~ Kec	urrent	r			3 weeks
	Examiner			Brazi		umo	(F					sluce aget
	P ==	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Dula to lor ms							-	
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as		toppe of):						
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687	ficate physis the			d								
Box	n certi anding use a	by Physician/Medi	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Tectopic pregi				23d. Date of de	livery
B	e death	sicia	in the past 12 months? 1 ☐ Yes 2 ②No	4□Pregnant a			Other (speci			_	Month	Day Year
P.O.	nat the d by tl etach	Phy	9 Unknown			ilting in the	n doubling cour	o sives is Dest I	220	and tobooo	o una pontributa t	the cause of death?
ds,	ires th signer	by	Part II. Other significant conditions  No.	contributing to death i	out not rest	alling in the u	ndenying caus	se given in Part i.		Yes		robably 4 Unknown
Sor	v requ been should	Completed	7.0						_	Vas an		
Re	he lav e has age 2	dmc							a	utopsy erformed	prior to death?	utopsy findings available completion of cause of
ita	ian: Trifficat	Be C	25. Was case referred to medical					26. Place	of Death (Check o	es 2[ <b>x</b> nly one)	No 1 LIYes	2 □ No
_ >	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 No	Hospitaf: 1 ☐ Inpati	ent 2	ER/Outpatier	nt 3 DOA	Other: 4 Nu	rsing Home 5	Residence	6 □Other (Spe	ecify)
n o	Ing P		27. Manner of Death 1   Natural 5 □ Pending	28a. Date of Inju (Month, Da		28b. Time o Injury		Injury at Work?		ibe how ir	njury occurred	
Division or Vital Records,	death.	icati	2 Accident investigation 3 Suicide 6 Could not	oe 280 Place of in	iun/ - At ho	nme farm et	M	1 ☐ Yes 2 ☐ N		on (Stroot	and Number or P	ural Route Number,
Σ	after after Direct	Certification:	4 Homicide determined	building, e	tc. (Specif	y)	, , , , , , , , , , , , , , , , , , , ,	11100	City o	Town, St	ate)	arai rioate Mulliber,
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	alc	29a. Certifier  (Check only 2 Medical Exa	hysician: To the best	of my kno	wledge, deat	th occurred at	the time, date an	d place, and due to	the cause	e(s) and manner a	s stated.
	the Ho lin 24 the Fu	Medical	one)	iminer: On the basis of and manner st	tated.	uion and/or ir			ith occurred at the t	me, date	and place, and du	e to the cause(s)
	with con	2	29b. Signature and title of certifier	Q <sub>n</sub>		1. D.	1	icense number			Date signed (Mon	
	l		7,000	W 11			ט	3358	7		1/4/07	
			30. Name and address of person wh	Scompleted cause of a		n 23a) (Type, ├) Ю	5213	Wisco	rsin Aux	#P14	Bethes	lu, 40814
	Sta	ate	31. Date filed (Month, Day, Year)	32. egist	rar's Signa		P		,		•	
	Regist	rar	JAN 052	2007	נ מו	OF A	2000					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland/ Department of Health and Mental Hygien@ State Registrar AMEND #29d PER PHY CCHD 1/5/07 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Flippen, Jr. 3:14 Ollie Roosevelt January 4, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown Mary's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Yrs. 577-54-8509 66 1940 Washington DC Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 23a or 28a-f ehow or other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14525 Burnt Store Road 20637 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Item. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: Specify White Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement 11 Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked other. Ollie Roosevelt Flippen, Sr. Doris Marie Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra T. Flippen - Wife 14525 Burnt Store Road, Hughesville, MD 20637 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page Department of Important: If eny Injury or once. Cedar Hill Cemetery 1-8-2007 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) M01391 22. Name and Address of Facility 21. Signature of Fune al Service Licensee 3035 Old Washington Road Waldorf, MD 20601 Huntt Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not after the mode of dying, suit as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequ Division of Vital Records, P.O. Box 68760. use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 1 Yes 2 No Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ■ No 1 🗀 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending 1/ Natural 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) le of certifier 29d. Date signed (Month, Day, Year) 29b. Signature and 1/4/07 WB use of death (Item 23a) (Type, Print) 30. Name and add ess of person who come 24035 Three Notch Road, Hollywood, MD 20636 James Jarboe, 31. Date filed (Month, Day, Year) State 200 Registrar JAN 05 mark

			For State Registrar	State	of Marylar		irtment of H	lealth and M Death		ene 007	01580
			Decedent's Name (First, Middle)	a, Last)	<del></del> *				2. Date of Death		3. Time of Death
	Physici		Dorothy Eli	zábeth G	urath				SON WOIL	Day Yea	
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	r Location of Death	2000	4c. County of De	
			Washington Co	unty Hos	nital		Нас	erstown		Washin	gton County
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. E	irthplace (State or Foreign Country)
	Director		212-24-5354	1 □ M 2 💢 F	7	79 Yrs.	Moritario Day o		Oct 16		Maryland
	A		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
į	a ho	ō		·							1 ☐ Yes 2 ☑ No
3	289-	Director	Maryland Wash	ington		нав	erstown 10f. Zip Code		100	. Citizen of What	Country?
4	osain win ine maryland ims 23a or 28a-f show ir inust be notified at		17950 Garden	Lane				740		U.S.	
1	16 27 17 2 27	Funerai	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13. V	Vas Decedent of H	ispanic Origin? (Spe	ecify Yes or No-		merican Indian,
0	or Iter	Fur	1 Never Married 2 Marr	ied 1 ☐ Yes	2 No	į.		an, Mexican, Puerto	Rican, etc.)	Black, W	-
20	ral', o	þ	3 Widowed 4 ☐ Divorced	If Yes, G Year or			I□Yes 2)(□No	Specify:		Specify:	White
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5	d Mer mark matic	٢	Russell Josep			10h Mailie	m Address (Street	Pea and Number or Rura	arl Eliza		
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aitimoi	permit. Pages 1 and 2 should be tiled within 72 frouts after dearn with the marylar Department of Heelith and Mental Hygiene. Department of Hem 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examinar must be notified at angle.		1 Burial 2 Cremation 4 Donation 5 Other (S	3 Removal from	n State	cemetery, crer	natory or other plac	(e)			
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٠,	hysician		shock, or head allure. List Immediate Cause (Final	only one cause on	each fine.	par har					Interval Between Onset and Death
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o j	the dr by the	Physician/Me	1 ☐ Yes 2 📆 No 9 ☐ Unknown	9☐ Unk		164(11 5)	TOther (specify)				
7	mar med by deta		Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
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0	ath. or: Af	atic	1 Pendin 2 Accident investig	gation	,,	,u.,y		Yes 2 □No			
noision	r Att	Certification:	3 ☐ Suicide 6 ☐ Could and 4 ☐ Homicide determined	ined 289. Plac	ce of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
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	lo the Hospital of Attanding within 24 hours efter death. To the Funerel Director: Attencompletely filled in by the fune	ledicai	29a. Certifier 1 Certifyir (Check only one) 2 Medical	Exeminer: On the	he best of my kno basis of examina anner stated.	owledge, death ation and/or in	occurred at the ting restigation, in my o	ne, date and place, pinion, death occurr	and due to the cau red at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
;	Withir To th Comp	Me	29b. Signature and title of certifie	·			29c. Licens	e number		I. Date signed (Mo	_
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5+	1-10		30. Name and address of person		01 0	0 0	Print)	1- 11	1.1 2	171/4	
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature (	in	1179,00	-a L	1/40	
	Registr		JAN 1	0 2007	Marina	S. A.	ale				

			For State Registrar	State of Marylan	d / Depa	ırtmen		Mental Hy	•	01581
			Decedent's Name (First, Middle, Last	)				2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Iris Leona Gri	ffin					, 2007 Year	12:08 a <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give			4b. City,	Town, or Location of Deatl	n	4c. County of Death	
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	Funeral Director			1 2 m 2 m 2 m 73	Yrs.	Months		(Month, Da	2, 1933	place (State or Foreign ntry)
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3	the Maryis	rector	Maryland Talb	ot		10f. Zip	Easton		10g. Citizen of What Cour	1 ☐ Yes 2 ☑ No
99	h with	a D	9320 Unionville Re	d.			21601		US	SA
36	within 72 hours after death with the Maryland ane. than 'natural', or Iteme 23a or 28a-f ehow he Medical Exacting must be profilled at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Deced Yes, spec	lent of Hispanic Origin? (S ify Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - Americ Black, White, Specify:	can Indian,
Baltimore, Maryland 21215-0036	s within 72 hou plane. In than "natura the Medical E	Completed	15. Decedent's Edu (Specify only highest grad	le completed)  College (1-4or 5+)	(Give I	lent's Usua kind of wor DO NOT us Lal We	Il Occupation k done during most of wor e retired)	rking	16b. Kind of Business/In  State Gove:	dustry
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ylanc	e d fa	To Be	James Milton Mondo				Mol1	ie Newb	y	
, Mar	1 end 2 should Heelth and Mer terr 27 ie marks		19a. Informant's Name/Relationship (T) Michele Griffin M		19b. Mailin r 4129	g Address Shani	(Street and Number of Runon Dr., Bal	timore,	nr, City or Town, State, Zip MD 21213	Code)
nore	Pages 1 on the lint: if item inty or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Place of Disposemetery, crem	natory or o	ther place)	Date /4/2007	20c. Location - City or To	
Baltir	permit. Pages 1 end Department of Heelth Important: if Item 27 any injury or other to		21 Signature of Funeral Service Licens				d Address of Facility nore Cremation Hudson Rd.,			
	_		23a Fart1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the deat						Approximate Interval Between
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ds, P.	uires that the signed by		Part II. Other significant conditions co	ntributing to death but not res	ulting in the un	derlying c	ause given in Part I.	23e. Did to	obacco use contribute to the	he cause of death?
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<u>a</u>	ilcian: The l certificete he rector, pege	ပိ	25. Was case referred to medical				00 81 18	1 ☐ Yes	2☐No 1☐Yes	2□ No -
ž	ysician: is certific director,	To Be	evaminer?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	1 3 DC	Othor	ath (Check only o	ne) tence 6 □Other (Specif	(v)
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Divisi		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special		eet, lactory	, office	281. Location (S City or Tow	Street and Number or Rura nn, State)	al Route Number,
	To the Hospital or within 24 hours effe To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred restigation,	at the time, date and place in my opinion, death occu	e, and due to the urred at the time,	cause(s) and manner as s date and place, and due to	tated. the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier			290	. License number		29d. Date signed (Month,	Day, Year)
			\$16N100	W.D		0	57040		01/04/2	207
			30. Name and address of person who can be seen as a seen and address of person who can be seen as a seen and address of person who can be seen as a se	700 105 A	turor	_	st. can	nb/idge	2, MD 21	613
	Sta Regist	ate rar	31. Date liled (Month, Day Year)	9 2007 Register's Signa	ature &	ho	de la			

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** PAPER ALEXANDER 4:05P <sup>™</sup> GREEN January 01 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) 1922 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Yrs. 361-12-9692 Director Indiana 84 February 16, Usual Residence of Decedent with the Maryland \*how 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Itsm 27 is marked other than "nature!", or itsms 23a or 28a-1 shov other traumatic svent, its Madical Examir at must be notified at 1 Tyes 2 No Completed by Funeral Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15115 Interlachen Drive, Apt. #726 20906 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other then "naturel", or items 23 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Paper 2 Rachael Gertler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra Paul - Daughter 1418 Highland Drive, Silver Spring, Maryland 20910 Date 20c. Location - City or Town, State Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mt. Lebanon Cemetery 1/3/2007 Adelphi, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.

11200 Matz Hampshire Ave., Silver Spring, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD20904 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed as the burial transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 2 4 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1. Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending s after death.
It Director: Aft
of in by the fur 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 20832 20 gistrar's Signature 31. Date filed (Mon State 2007 Registrar

07-00264 Cur	CC	rie Gill Please Type or Print in Black Indelible Ink. Ensur	re All Copie	s Are Lec	iihle	
UNK UNK		State of Maryland / Department of Health an  1-For State  Certificate of Death	nd Mental H	/giene		7 0170
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)	<u>-</u>	2. Date of Deatl		3. Time of Death
Medical Exami	ner	MARJORIE DENISE GILL  4a Facility Name (if not institution, give street and number)  14b. City. Town, or	r Location of Death	Month January 9,	2007 Year 4c. County of Death	1631 hrs
		Montgomery General Hospital Olney			Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes Months Day 1 M 2 X F 38 Yrs.		8. Date of Birt Aug 24	h(MM/DD/YYYY) 9. Bir Foreig Co	
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d Inside City Limits
ж	or	Md Montgomery Gaithersburg	9			1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other trannatic event, the Medical Examiner must be notified at once.	I Director	10e. Street and Number 206 Park Ave, # 107 2087	77	10	g. Citizen of What Cou	ntry?
leath wit	Funeral	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hi 14 Yes, specify Cubar 15 Yes, specify Cubar	ispanic Origin? ( Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14 Race - Amer White, etc.	ican Indian, Bíack,
s after d ural", or	þ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No			Specify Bla	
5 72 hour in "natu	leted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupa during most of working life	e. DO NOT use retir	ork done red)	16b. Kind of Business/	,
5-0036 iled within 72 Hygiene I other than the Medical	Completed	4 Yrs Event Coorid:	inator 18 Mother's Name	(First Middle M	Dept Of He	ealtn 
21215 unld be file Mental H marked o	o Be (	Eligie Gill  19a Informant's Name/Relationship (Type Print )  19b Mailing Address (Street	Wilma	J. Go	och	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Nental Hygiene Important: If item 27 is marked other than "natural", injury or other tranmatic event, the Nedical Examiner	ř	(0.00	et and Number or F Ave, Pas	lural Route Numi Badena ,	ber, City or Town, State Md #21122	e, Zip Code)
Baltimore, MD oemit Pages I and 2 sho Department of Health and Important: If item 27 is njury or other transmail		20a. Method of Disposition  20b Place of Disposition (Name of ce Rivernatory Prother place)  Removal from State Rivernatory Prother place)		Date	20c. Location - City or	
altim mit Pa partmen portant ury or o		4 Donation 5 Other Specify  Cremato: 21 Signature of Funeral Service Licens  22 Name and Address		.5/07	Hyattsvill	
m និង∄≣ Physician	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying			20850 ckville, Mo	
/Medical		Immediate Cause (Final disease a Hypertensive cardiovascular disease		respiratory arre	st, shock, or fleart	Approximate Interval Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
	Examiner	if any, leading to immediate course French Dule for as a consequence of):  (Disease or injury that initiated course of the cours			-	
ecuted and transit	_	events resulting in death) Last  Due to (or as a consequence of):  d		_	· · · · · · · · · · · · · · · · · · ·	
0, be exection are sician are ourial - to	edica	X UNPENDED #23a,PII,27,perME, G864, 2/2	2/07 TT			
Box 68760, death certificate be exche attending physician effor use as the burial	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3		ncy	23d. Date of delivery	) Day Year
Box: death c	Physician/Medical	1 Yes 2 No 9 ✓ Unknown 9 Unknown Other (Specify)				
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and inplietly filled in by the funeral director, page 2 should be detached for use as the burial - transing the contract of the con	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause Obesity	given in Part I		pacco use contribute to	
cords, P.O. law requires that has been signed be east	leted			24a. Was a	n 24b. Were au	topsy findings available completion of cause of
Division of Vital Records, ral or Attending Physician: The law requirers after death.  In Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed			perform	ned? death?	
Vital ysician: his certif	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	of Death (Check of Other Nursin		Residence 6 Other	,
n of Vi ding Physi h. After this	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury	ury at Work?		ow injury occurred	
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Divis Hospital or At 24 hours after d Funeral Direc		4 Homicide determined (Specify)		or Town, St		
To the Ho within 24 b completely	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, done)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated	late and place, and n, death occurred a	due to the cause t the time, date a	e(s) and manner as state and place, and due to the	ed e cause(s)
	Ž	29b. Signature and title of certifier  29c. Licens	se number		29d. Date signed (Mod January 10, 2007	
		30. Name and address of person who completed cause of death (Item 23a)	-			
	ate	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore,  31 Date filed (Man 1) Pay, Year 2007 32. Jegistrar's Signature	MD 21201			
Regist		31 Date filed (Mg/hthplay, Year) 2007 32. Figistrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician GIBBONS** 11:20p <sup>M</sup> JAN. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Mar. 2, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months 1 □ M 2 🔀 F 1922 North Carolina Director 579-20-0893 Usual Residence of Decedent 10c. City, Town or Location 10b County 10d. Inside City Limits 28a-f show a or 28a-f sho 1 ☑ Yes 2 ☐ No Directo DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20010 625 Keefer Pl. N.W. 238 Funeral USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: ð 3K Widowed 4 ☐ Divorced Year or Dates: **Black** 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Association of Broadcast Houskeeping 2nd 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Tillman 2 unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is 20010 625 Keefer Pl. N. W. Washington, D.C. Melvin Gibbons/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State Ft. Lincoln Cemetery 1-9-2007 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. Washington, D.C. 20011 4217 9th St. N.W. 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GASTROINTESTINAL ACUTE /Medical Due to (or as a consequence of) **Examiner** NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes → No 24a. Was an autopsy perform this certificate 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient P 2 ER/Outpatient 3 DOA 27. Manner of eath 28a. Date of Injury (Month, Day 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred eral Director: After filled in by the funer 5 Pending investigation 1 🗌 Yes 2 ☐ No 2/ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State

Ribbons, SARAH

31. Date filed (Month, Day, Year) JAN 0 8 200 Registrar

29b. Signature and title of certifier

30. Name and address of person who

Alpana Goswami

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

M.D.

MID.

8600 Old Georgetown RD.

29c. License number

29d. Date signed (Month, Day, Year)

Bethesda, Md. 20813

07

Examiner The law requires that the death certificate be executed physicien and s the burial-transit Division of Vital Records, P.O. Box 68760, attending ph ed by the a this certificete has been si ral director, page 2 should or Attending Physician: After after deat

To the Hospital

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within 2

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**Physician** 

/Medical

Examiner

Md.

Director

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**Funeral** 

Director

Item 27 is marked other than "natural", or iteme 23a or 28a-1 ehow other treumstic event, the Madical Examiner must be notified at

2 should be filed within 72 hours after a and Mental Hygiene is marked other than "natural", or ite

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or othar traum once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

death with the Maryland

Physician/Medicai IF FEMALE 23b. Was decedent pregnant in the past 12 months? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 25. Was case referred to medical Be examiner' P 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 5 Pending investigation М 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

January 8,2007

20707

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year) 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

William A. Warren, M.D. 321 Prince George St., Laurel, Maryland

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			For State Registrar	State of Ma	rytand / Depa Cel	rtificate of			g. No.	, ,	, , ,
	Physici	an	1. Decedent's Name (First, Middle, Las	" 6	EORGE			Date of Death     Month	Day	2007	3. Time of Death
	/Medic	al	EOWARD  4a. Facility Name (If not institution, give		LOICAL	4b. City. Town.	or Location of Death	01	4c. Coi	unty of Death	(0),
- Gar	Examin	er	5907 Upper Court				owie			ince Ge	orge's
	Funeral	=::-	5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year)	9. Birthpla Count	ace (State or Foreign
wi.	Director		220-51-4396 Usual Residence of Decedent	201	45 Yrs.			Nov 3, 1	L961_	Sierr	a Leone
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10	Od. Inside City Limits
	a-f sh	ctor	Maryland Prince	George's		Bowie					1 AYes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code	721	10		of What Count	-
	s 23a	erai	5907 Upper Court	12. Was Decedent E	ever in U.S. 13			pecify Yes or No-		ra Leon	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Examinat must be trailled at	Completed by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	Armed Forces?  1  Yes 2 XN If Yes, Give Year or Dates:	0	If Yes, specify Cut  1 ☐ Yes 2 ☑ No	Hispanic Origin? (S pan, Mexican, Puert Specify:	o Rican, etc.)		Black, White, e	
2-0	72 ho 'natur	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	dent's Usual Occu	pation during most of wor ad)	rking	16b. Kind	of Business/Ind	ustry
121	within iene. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)		assistant		D	rivate	
	Hygie Hygie other	e Co	17. Father's Name (First, Middle, Last)			Nursing 1		ne (First, Middle, M			
lan	Mental Mental arked o	To Be	Rashid T. George	9			Eliz	abeth Mea	ama-K	ajue	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me		19a. Informant's Name/Relationship (	· .	1		t and Number or Ru			wn, State, Zip	Code)
	l and fealth m 27		Jonathan George  20a. Method of Disposition	(Brother)			ourt, Bow			ion - City or Tov	wn State
Baltimore,	8 ° = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispersion of Commetery, cre		l				
Itin	artmen ortant: injury		4 □ Donation 5 □ Other (Specification 21. Signature → Fureral Service Licer		Mt. OLIV	et Cemeto 2. Name and Addr	ery 1/13  ess of Facility Re	/2007 <b>V</b>	Vashi Etm	ngton, oral Ho	DC
Ba	Depariment of the permit of th		Muchin	9) and			polis Roa				THE
No. of the last of	Physician /Medical Examiner	Jer /	23a. Pay Enter the disease, or compose, or heart failure. List only lamediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Excellenting	a	a consequence of):	ma	11g, 5001 as saram	or respiratory and			Approximate Interval Between Onser and Death
68760,	ificate be executed g physician and as the burial-transit	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or mighty that initiated events resulting in death) Last	c	a consequence of):						
P.O. Box 6	requires that the death certific een signed by the attending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су		23d	. Date of delive Month	ry Day Year
	res that igned b	by Pi	Part II. Other significant conditions of	contributing to death be	ut not resulting in the I	underlying cause g	iven in Part I.	23e. Did tob	acco use	contribute to th	e cause of death?
ord	w require been sig should to	ted						1 🗆 Ye	s 2 1/1	lo 3 Proba	ably 4 □Unknown
Division of Vital Records,	The law late has b page 2 si	Completed						24a. Was ar autops perform 1 \( \text{Yes} \) 2	У	prior to con death?	psy findings available inpletion of cause of 2 No
Vite	Attending Physician: Thrideath. ector: Alter this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			thon	ath (Check only on		7015 / C	.1
o	Phys r this aral di	To To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Injui (Month, Da)		of 28c. Ini	ury at	28d. Describe ho		Other (Specify courred	')
ion	nding F th. r: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		Year) Injury		ork? □Yes 2□No				
Divis	ai or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined		ury · At home, farm, s c. (Specify)	treet, factory, office	3	28f. Location (St. City or Town	reet and N n, State)	lumber or Rura	l Route Number,
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examone)	nysician: To the best miner: On the basis of and manner sta	examination and/or in	nvestigation, in my	opinion, death occi	urred at the time, d	ate and pla	ace, and due to	the cause(s)
	To	2	29b. Signature and title of continued  Hospite of the	chief Medio ne Chesape	cal Office ake	r,	21438	2		igned (Month, I	
	X-		30. Name and address of person who								
	(4/)	ate	Michael J. LaPe	32. Registra	ar's Signature		way, Anna	pol <b>i</b> s, MI	214	01	
200	Regist		JAN 0 8 2007		B. Anse	L)					
DH	HMH 17 Rev 1/	2001	JAN UO LOUI	PHAREM	1						

State of Maryland / Department of Health and Mental Hygiene

1 = For State Registral Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vaar Physician MARY ELIZABETH GWYN January 3, 2007 4:53 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice Mt. Airy Frederick 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Min Months 1 □ M 2 🖾 F Director 198-18-1759 81 Feb. 10, 1925 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f ehow item 27 ie marked other then "natural", or itema 23a or 28a-f ehov other traumatic event, the Modical Examinar must be notified at 1 X Yes 2 No Director Greenbelt Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 12 B Ridge Road 20770 U.S.A. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 2 3 ☐ Widowed 4 ☒ Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. 7 ie marked other then "ne Elementary/Secondary (0-12) College (1-4or 5+) US Government/Dept. of Interior 12 Sample Control Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Clink Elizabeth Heller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 st Department of Health and Importent: if item 27 ien any injury or other traun Mary Alice Blare - Niece 1310 David Lane, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD Lakemont Memorial Gardens 1/8/2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. andette - Dasch Janning Hyattsville, MD 20781 Gasch's Funeral Home, P.A., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia weeks /Medical Due to (or as a consequence of): Examiner Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 🛾 weeks Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit the death certificate be executed Non Small Cell Carcinoma Lung 3 years Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 9 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown pleted 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has t Com 2□ No 1 Yes 1 Yes 2 💢 No director, 25. Was case reterred to medical Be 26. Place of Death (Check only one) Hospice examiner? Other: 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑Other (Specify) House this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of After or Attending 1 X Natural Injury 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours 6 Funerel [ Hospital 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical mpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lloyd E. Halvorson, MD 1475 Taney Avenue, Suite 204, Frederick, MD 21702 JAN 0 8 200 32. Registrar's Agnature Registrar

				State of Man				•	_	
			1 - For State Registrar	State of Mary		rtificate of			2001	0   588
			Decedent's Name (First, Middle, Last)					2. Date of Deat	ig. No.	3. Time of Death
H	Physici /Medio		June Rae Grab					January	3, 2007	9:20 PM
	Examin		4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, o	or Location of Death	·	4c. County of Deatl	
			Union Hospital of			E1kton			Cecil	
	Funeral		5. Social Security Number 6. Sex 1 1	7. Age (II	n yrs. last birthday Q 9 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		82 Yrs.			June 18	,1924 Mai	ryland
	yland		10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	Ba-fa	ctol	Maryland Cecil		Charle	stown				1 XXYes 2 ☐ No
	or 28	Dire	10e. Street and Number			10f. Zip Code	_	10	g. Citizen of What Co	untry?
	death with the Maryland rme 23s or 28s-f show rmust be notified at	ral	531 Calvert Stree		-1-110	21914		-	United Stat	
	ter de	ů,	11. Marital Status 1 ☐ Never Married 2 ☐ Married	<ol> <li>Was Decedent Eve Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No</li> </ol>	rin U.S. 13.	If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
036	ursal	by	3\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	tf Yes, Give Year or Dates:		1 ☐ Yes 🏖 No	Specify:		Specify: Wi	nite
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	pation during most of work	kina	16b. Kind of Business/l	ndustry
21215-0036	be filed within 72 hours after death with the Marylan lat Hygiene id other than "natural", or itema 23s or 28s-f ahow avant, the Medical Examinar must be notified at	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)			
2	filed v Hygie other i		17. Father's Name (First, Middle, Last)			dministra	T	ne (First, Middle, M	Highway	7
an	uid be Vental Irkad c	To Be	Norman Ray Warrer	ı					ia Granadie	er
Maryland	shou and M mar umat	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mail	ing Address (Street			City or Town, State, Z	
	ges 1 and 2 should t of Health and Men if item 27 is marks or other traumatic		Henrietta Copenhave	r / Niece	101 W	est Walnı	ıt Street	. North I	East, Mary	land 21901
Baltimore,	ges 1 a of Hea if Itam or othe		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ce) Jan	Date uary	20c. Location - City or	Town, State
ţij	: Pag tment tent:		4 □Donation 5 □ Other (Specify)			Anne Ceme	. "1.	2007	North East,	Maryland
Bal	permit. Pages 1: Depertment of He important: if itan any injury or oth		21. Signature of Funeral Service License			2. Name and Addre	CL		eral Home	
			23a. Part1. Enter the disease, or complic	ations that caused the	death. Do not en	27 South ter the mode of dvi	Main Str	eet, Nort	ch East, Ma	ryland 2190
	Physician		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.		1. 1.		or recognition, and	,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co	onsequence of):	1715				SUMES
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	bd sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of as a co	onsequence of):	1	$\wedge$			-
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68	death certificate t ettending physi of for use as the b		a.		1		, , , ,	37.2	2	
Вох	death certifica e ettending ph ed for use as th	M/UR	230. Was decedent pregnant	c. If yes, outcome of p		☐Ectopic pregnanc			23d. Date of deli	very
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Bě	9 9 9	Completed	11/12/1/11/20	1/4/0	1	1		24a. Was ar autopsy perform	prior to c death?	opsy findings available ompletion of cause of
tal		0	25. Was case referred to medical	Rap	104/7.	1	26 Place of Dea	1 ☐ Yes 2	☑No 1 ☐ Yes	2□ No
f V	nysici iis cer direc	To B	examiner?	spital: Inpatient	2 ER/Outpatie	nt 3□ DOA Ott	100		nce 6 □Other (Spec	ify)
0 0	ng Pt		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	of 28c. Injur	y at rk?	28d. Describe hor	w injury occurred	
sio	Attanding ir death. actor: Ater by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division of Vital Records,	or Al efter of Dirac	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (S		reet, factory, office		28f. Location (Str City or Town,	eet and Number or Ru , State)	ral Route Number,
_	lospitel or a hours efter unarel Dira		29a. Certifying Phys	cian: To the best of m	ny knowledge, dea	th occurred at the til	me, date and place	and due to the ca	use(s) and manner as	stated.
	To the Hospitel or Attending Physicien: within 24 hours effer death. To the Funerel Director: After this certific completely filled in by the funeral director,	edicai	(Check only 2 Medical Examin one)	er: On the basis of ex and manner stated	amination and/or it	nvestigation, in my o	ppinion, death occur	red at the time, da	ite and place, and due	to the cause(s)
	with.	Σ	29b. Signature and title of certifier	0	/ .	29c. Licens	se number	29	d. Date signed (Month	, Day, Year)
•			" theree	amile	410	100	0650	734	January	4,2007
	6		30. Name and address of person who cor	npleted cause of deat	(Item 23a) (Type	Print)	Elleta	~ MO	2/92	,
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's	Signature	No.		- '0	-172	1
	Registr		JAN 0 8 2007	Blower.	15 1998					

			For	State of Ma		d / Depa	artmen	t of H	ealth a		•			01589
			1 State Registrar			Cer	tificate	e of l	Death			eg. No.		
	Physicia	an	1. Decedent's Name (First, Middle, L. IRENE M	GLG-NAC							Date of Dear     Month	Day	Year	3. Time of Death
	/Medic						41 01	<b>-</b>	Location of		January			9: 32 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, gi				,						nty of Death	
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	pu ,		Usual Residence of Decedent		10+ Cit	, Town or Lo								10d. Inside City Limits
	ahow	7.	10a. State 10b. County		_		cation							1 □ Yes 2 No
	the N 28a-f	ecto	MD Calvert  10e. Street and Number	County	OW	ings	10f. Zip	Code				0g. Citizen o	of What Cou	intry?
	with 3a or	io	9010 Mary Ann D	rive				0736				U.S.		,
	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. ad other than "natural", or items 23a or 28a-f ahow adother than "natural", or items 23a or 28a-f ahow avent, ite Madical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.	S. 13. V			spanic Original	gin? (Spe	ecify Yes or No- Rican, etc.)			ican Indian,
0	after or Ita	/Fu	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☑ No	0		1 ∏ Yes 2		Specify:	i, rueito	nican, etc.)	1	lack, White city: Wh	
200	ural',	d by	3 Widowed 4 Divorced	Year or Dates:										
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land	Jid be Aenta rkad tic av	5 B	Leroy Greenwal	.d					Hel	en L	ouise R	eese		
Магу	2 should be and Mental Is marked sumatic av		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address	(Street a	and Numbe	or or Rura	A Route Number	, City or Tow	n, State, Zi	p Code)
Σ.	2 4 5 E		Joseph E. Gignac	(Busband)	,	9010	Mary	Ann	Driv	e, 0	wings,	Maryla	nd 20	736
ore	Pages 1 ar nent of Hea int: If Item iry or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3	□Removal from State		ace of Dispo				Jan [		20c. Location		
baitimor	t. Pa tmen tent:		4 ☐ Donation 5 ☐ Other (Spec		Mar	yland								Maryland
g O	permit. Pages Department of t Important: If its any injury or o once.		21. Signature of Funeral Service Lice	ensee		22	. Name an	d Addres	s of Facilit	y Lee	Funera	l Home	Calv	ert, P.A.
			Michael W. Le 23a. Part1. Enter the disease, or cor		the death	8	125 S	outh	ern_M	aryl	and Blv	d., Ow	ings,	MD_20736
			shock, or heart failure. List ont Immediate Cause (Final	y one cause on each line	э.							,		Interval Between Onset and Death
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XOD	requires that the death certificat een signed by the attending phy nould be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of								23d. D	Date of deliv	verv
ň	death e atte d for	icial	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t			]Ectopic pr ] Other (sp						Month	Day Year
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ກ້	w requires that s been signed t should be det	by P	Part II. Other significant conditions	contributing to death bu	t not resu	ulting in the u	nderlying c	ause give	en in Part I.	,		/		the cause of death?
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	Physician: The law this certificate has ral director, page 2 a	Co		_							perform 1 Yes	2 Ø No	death? 1 ☐ Yes	2 No
\ [a	sician certif rector	Be	25. Was case referred to medical examiner?	Hospital:	- 7-7			Othe	nc.		Check only or		1 - 100	
5	Phys r this arat di	. To	1 ☐ Yes 2 ☐ 4No 27. Manner of Death	1 ☐ Inpatier 28a. Date of Injun (Month, Day		ER/Outpatien 28b. Time of		8c. Injun Work	4 🗆 Nu		me 5 Reside			fy)
0	ading th: : Afte	tior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Year)	Injury	м		k? Yes 2∐l	No				
DIVISION	Atter	ifica	3 ☐ Suicide 6 ☐ Could not determine		ry - At ho	me, farm, str	eet, factory	, office			28f. Location (Si City or Town	reet and Nur	n <i>ber or Rui</i>	ral Route Number,
5	talor rs afte al Dir ed in	Certification:	Tiomode	building, etc.	. (Зреспу	,					Oily or Your	1, O(a(6)		
	To the Hospital or Attending Physician: within 24 hours alter death To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	(Check only 2 Medical Exa	Physician: To the best of miner: On the basis of	f my knov examinat	wledge, death	occurred vestigation.	at the tin	ne, date an	d place, a	and due to the c	ause(s) and r	nanner as	stated. to the cause(s)
	the the mplet	Med	one) 29b. Signature and title of certifier	and manner stat	ed.				number			9d. Date sign		
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		18	30. Name and address of person who		ath (Item	23a) (Tune	Print)			-		,		-
	15		SA JIDA	CHAUDRY,	MI	132 Δι	าทล <b>า</b> กำ	lis	Rd.	Oden	ton. Ma	rvland	2111	3
	Sta		31. Date filed (Month, Day, Year)	4 2007	s Signa	ture		.M	-w. •	Juci		- y raila		
	Registr	ar	JAN (	) 4 ZUU/	Est. M.	, 15.	Sec.	BELL P						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item #2 State of Maryland / Department of Health and Mental Hygiene State Registrar WCHD/SH 1/16/07 per Dr. Certificate of Death Reg. No. Reg. No. 2. Date of Death Jan. 8, 2007 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2158 **Physician** Holman Lee hard /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day, Year) Sep 18, 1957 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days **X**□M 2□F Months Hours 176-46-7223 49 Director Usual Residence of Decedent 10d, Inside City Limits 10a State 10b County 10c. City, Town or Location rai" or items 23a or 28a-f show Examiner must be notified at PA Franklin Waynesboro 1 X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 1 264 Park Street 17268 USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ TNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance mechanic U S Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard G. Helman Elizabeth Ann Matthews ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) wife P 0 Box 521, Waynesboro, PA 17268 Penny L. Helman 20b. Place of Disposition (Name of cemetery, crematory or other place)
Burns Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan 13,2007 Waynesboro, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of Funeral Service Licensee 50 S. Broad St. Waynesboro, PA 17268 Dowerson Approximate Interval Between Onset and Death 23a. Part1. If there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hours **Physician** ainsten /Medical Due to (or as a consequence of): Examiner Due to for as a consequence of). Sequentially list conditions, if any leading control cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the th attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a I□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed/ 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 1 Inpatient this 28b. Time of 28d. Describe how injury occurred after death.

I Director: After to d in by the funeral 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

of death (Item 23a) (Type, Print)

istrar's Signature

of person who completed cause

2007

alas

Year)

31. Date filed (Month,

			Please	State of Manuage					•	
			1 _ For State	State of Maryland		artment of F rtificate of			71111	01591
			Registrar  1. Decedent's Name (First, Middle, Las	*1	00	runcale or	Dealii	2. Date of Deat	ng. No.	3. Time of Death
	Physici		Joseph Thomas		Sr			Month	y 6, 2007	10:25A M
	/Medic Examin		4a. Facility Name (If not institution, give				r Location of Death	•	4c. County of Deat	
			5420 Peach Tree I	Orive		Car	mbridge		Dorche	
	uneral		5. Social Security Number 6. Se	ZIM OFF	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	holace (State or Foreign untry)
	irector		217-52-0585 '2 Usual Residence of Decedent	59	113.			Feb 5,	1947 Pe	nnsylvania
yland	Now H		10a. State 10b. County		Town or Lo					10d. Inside City Limits
J ∰	S - C	cto	Maryland Dorches	ster		Cambrid	ge 			1 ☐ Yes 2XXXIo
death with the Maryland	Le Do	Director	10e. Street and Number	Davissa		10f. Zip Code	C1.2	10	0g. Citizen of What Co	ountry?
2 ै	18 238	era	5420 Peach Tree	12. Was Decedent Ever in U.S	13		513	acify Ves or No-	US 14. Race - Ame	nican Indian
after de	Fee	Funerai	11. Marital Status  1 □ Never Married 200 Married	Armed Forces?  1 Types 2 No If Yes, Give			lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
OUrs a	el'.o	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1966—	77	1□Yes 2₩No	Specify:		Specify:	White
within 72 hours	of other then "naturel", or thems 23a or 28a-f show event, the Mudical Exerciper must be notified at	Completed	15. Decedent's Ed (Specify only highest grades)	ucation de completed)	(Give	dent's Usual Occup	during most of worki	ng	16b. Kind of Business	Industry
within 6	L Pe	I du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	maintena	•		school b	ard
	nt, u		12 17. Father's Name (First, Middle, Last)			MOTITECIA	18. Mother's Name	(First, Middle, N		Sara
d be	ked c	To Be	Samuel Hendric	cks			Ver	ma Kisl	h	
arylal should b	is marked raumatic ev	-	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street			City or Town, State, 2	
2 0 5	, N		Janie L. Hendrick			Peach Ti			dge, Maryla	
Pages 1	If iter or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐			osition (Name of matory or other place			20c. Location - City or	
Dallimor	Important: If item 2 eny injury or other once.		4 Donation 5 Other (Specify			y Cremato			Salisbury,	Maryland
	eny ir		21. Signature of Funeral Service Licen	500	2	Thomas Fu	iss of Facility Ineral Hom	e, P.A.	_	
			23a. Part . Enter the disease, or comp	vilications that sed the death.	Do not en		st Street			Approximate
Prov	sician		shock, or heart failure. List only of Immediate Cause (Final	ne cause in each line.	at	èc	rau	My		Interval Between Onset and Death
/N	ledical		disease or condition resulting in death)	a Due to (or as a conseque	ence of):			•		11110111115
Exa	miner		Sequentially list conditions,	b						
Pe Pe	ij	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					
xecut	and al-tran	Examine	that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):					
/ou, le be executed	ysicien and ne burial-transit	calE	l	d						
Certificat	attending physi I for use as the t									
th ce	tendir r use	Physician/Medi	230. Was decedent pregnant	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of		∃Ectopic pregnanc	v		23d. Date of del	
o death	the at hed fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of dea 9 ☐ Unknown	ith 5[	Other (specify)	<u> </u>		Month	Day Year
Ords, P.O	been signed by the should be detached	Ph	Part II. Other significant conditions co	ontributing to death but not result	ting in the u	inderlying cause div	ven in Part I	23e. Did tob	pacco use contribute to	the cause of death?
Lires C	d be	d by				January my dadaba git	STATE OF THE STATE	1 □ Ye		obably 4 Unknown
law requir	shou	Completed						24a. Was ar	24b. Were au	itoosy findings available
The la	page 2	E O						autops	ned?// death?	itopsy findings available completion of cause of 2 No
	certificate rector, pag	0	25. Was case referred o medical				26. Place of Death	1 Yes 2		20140
ysic V	direct	To B	examiner? 1 🗌 Yes 2 🗹 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatie	nt 3□ DOA Ott	ner: 4 Nursing Hor	me 5 Reside	ince 6 Other (Spe	cify)
2 2	Vfter thundera		27. Manner of Death 1 L Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time o Injury	Wor		28d. Describe ho	w injury occurred	
Signal Si	the f	icat	2 Accident investigation 3 Suicide 6 Could not be		a form of		Yes 2 □ No	28f Location /Str	reet and Number or Ru	ural Boute Number
Lor Attending	Dire Jin by	ertification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, raim, si	reet, ractory, onice		City or Town		arar rioute reamber,
spita	y fillec	aic	29a. Certifier 1 Certifying Ph	ysician: To the best of my know	ledge, deal	h occurred at the tir	me, date and place, a	and due to the ca	luse(s) and manner as	stated.
he Ho	To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Examone)	iner: On the basis of examination and manner stated.	on and/or in	vestigation, in my o	opinion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
Tot	Com	Σ	29b. Signature and title of certifier	Ema?		29c. Licens	2 C V	7	9d. Date signed (Mon)	h, Day, Year)
			LANO .	DIVY			17780	/	1/8/0	/
			30. Name and address of person which	omposed cause of death (Item 2), M.D. 29466			nite 5 F	aston M	D 21601	*
8	Sta	at <u>e</u>	31. Date filed (Month, Day, Year)	32. Regissar's Signatu	ire			ascon, M	ــــــــــــــــــــــــــــــــــــــ	
	D			2007	No.	Acres 16 .				

07-00423 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ernest Hawkins 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day January 15, 2007 EARNEST LEVINE HAWKINS 0229 hrs Medical Examine 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Harford Harford Memorial Hospital Havre de Grace 5. Social Security Number If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Age (In vrs. last birthday) Funeral Months Days Hours Min Foreign Director Country MARYLAND 220-84-7271 1X M 2 F 41 03/21/1965 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d Inside City Limits 3nv 1 X Yes 2 No or items 23a or 28a-f show HAVRE DE GRACE MARYLAND HARFORD nours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country 10f. Zip Code notified at 564 GIRARD STREET 21078 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian, Black Armed Forces? White etc. 1 Never Married 2 Married Yes 2X No f Yes, Give Year 4 X Divorced 1 Yes 2 X No specify: Specify. BLACK "natural", Examine ₽ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) ges 1 and 2 should be filed within 72 ho t of Health and Mental Hygiene : If item 27 is marked other than "na other trannatic event, the Medical Exi Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12 BARBER BARBER SHOP 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be CALVIN BENJAMIN HAWKINS ETHEL WHITING 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD ETHEL HAWKINS / MOTHER 564 GIRARD STREET, HAVRE DE GRACE, MARYLAND 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 1 X Burial 2 Cremation crematory or other place) or other Removal from State Pages 1 Department o JAMES UNITED CEM. 1/20/07 HAVRE DE GRACE, MD Donation 5 Other Specify 21 Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A.

552 LEWIS STREET, HAVRE DE CRACE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MD 21078 Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Aortic dissection complicated by cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED attending physician or use as the burial -**AMENDED** 23a,27 2863, 1/25/07 TT .28a-f perME Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of deliver 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year 2 Fetal death Dav past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknowr the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate Yes 2 V No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica 26 Place of Death (Check only one) director, Division of Vital Be examiner? Hospital: 1 Inpatient Other<sub>4</sub> 2 PER/Outpatient 3 Nursing Home 5 Residence 6 Other this 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) After 1 27. Manner of Death 28b. Time of Injury 28d Describe how injury occurred 28c. Injury at Work? Yes 2 Certification Natural Director: Pending FNd 1/15/2007 Fnd 2:03 am unknown Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 564 Girard St. X Could not be Suicide 24 hours af
Funeral D
etely filled i (Specify) Homicide found in residence Havr<u>e de Gra</u>ce, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month. Day, Year) O.C.M.E. January 16, 2007 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registra

th, Day Year)

9

31. Date filed (Month,

32. Registrar's Signature

		,	1 - State of Maryland / Department of Pertification	t of Health and M <b>P</b> of Death	ental Hygi Re	iene 9. No. 2007	0   5 9 3
	til v	-11	Decedent's Name (First, Middle, Last)		2. Date of Death	h	3. Time of Death
	Physicia		Curtis Lee Harrington, Sr.		Month January	Day Year 4 2007	7:45 A M
	/Medic Examin			Town, or Location of Death	o caracar)	4c. County of Death	, , s -r J II.
		Ο.	Southern Maryland Hospital	Clinton		Prince	George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		8. Date of Birth (Month, Day,		place (State or Foreign
4 1/2	Director		242 <b>-</b> 08 <b>-</b> 5588		Oct. 4,	1958 North	Carolina
	nd >		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				I0d. Inside City Limits
	aryla shov	7	Too. State				1 DaYes 2 □ No
	he M 28a-f otifie	Director		Capitol Heig	hts	Og. Citizen of What Cou	ata/2
	with t	ä					_
	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	4805 Addison Rd., 101  11 Marital Status 12, Was Decedent Ever in U.S. 13, Was Decedent	20743	ecify Yes or No-	United 14. Race - Americ	
	ter d	Fun	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1. □ Yes 2 ☒ No	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
38	ırs af II', or xam	ρ	If Yes, Give 1 ☐ Yes 3 ☐ Widowed 4 1 ☑ Divorced Year or Dates:	2  ▼ No Specify:		Specify: Bla	ack
21215-0036	2 hou	Completed	15. Decedent's Education 16a. Decedent's Usua	al Occupation		16b. Kind of Business/In	dustry
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2	d with	Com		tenance Engin	eer _	Privat	:e
p	e file al Hy lothe vent,	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, N	flaiden Surname)	
<u>a</u>	ould b Ment arked atic e	70	Roger Lee Cross		Ruthie	C. Harring	gton
Maryland	2 sho and I Is ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address	(Street and Number or Rui	ral Route Number,	City or Town, State, Zip	Code)
Σ.	and sealth n 27			<u>innesota Ave.</u>			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  20b. Place of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition)		Date 2	20c. Location - City or To <b>Landover , M</b>	own, State
Ē	Pag ment tant: jury o		4 □ Donation 5 □ Other (Specify) Glenwood Ceme	etery 1/13	/2007	Wash., DO	<u> </u>
ä	epart epart nport ny In					Funeral Hon	
<u> </u>				Ol Benning Rd			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod shock, of heart fallure. List only one cause on each line.		or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Course (Final disease or condition resulting in death)	in hin			Oncor and Doasi
7	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	1			
	LAdiffiller	_	Sequentially list conditions, b. Due to Cur as a por securities of				
	ed sit	Examiner	cause. Enter Underlying			-1	
н	ecute and -tran	хап	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	al E	545 15 (5) 45 45 55 55 55 55 55 55 55 55 55 55 55				
87	cate physi	dical	d				
×	certifi ding se as	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of deliv	an/
8	eath aften for u	sian	in the past 12 months?			Month	Day Year
o.	the d	ysic	1 Yes 2 No 9 Unknown				
Division or Vital Records, P.O. Box	w requires that the death certif been signed by the aftending should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underlying of	cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
sp.	uires 1 sign Id be	d by	Pseudomembranon Colets		1 □ Ye	es 2 No 3 Pro	bably 4 Unknown
Ö	w req beer shou	Completed			24a. Was ar	24h Were auto	opsy findings available
Be	he lar has ige 2	ш			autops perforn	y prior to co	impletion of cause of
a	n: T ficate or, pa		25, Was case referred to medical	OS Place of Davi	1  Yes 2		2 No
5	sicia certi	o Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC			ence 6 □Other (Speci	6.1
ō	Phy er this eral d	<del> </del>		28c. Injury at Work?	28d. Describe ho	ow injury occurred	
on	nding th. :: Afte	tior	J Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M	Work? 1 ☐ Yes 2 ☐ No			
<u>ISI</u>	Atter deal	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factor	y, office		reet and Number or Run	al Route Number,
ă	after after Dire	erti	4 Homicide determined building, etc. (Specify)	9	City or Town	i, State)	
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  In the Funeral Director: After this certificate has been signed by the aftending it the Funeral Director after this certificate has been signed by the aftending it after this certificate. The page 2 should be detached for use as		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred				
	n 24   n 24   ne Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, iii my opinion, death occu	neu at the time, d	are and place, and due t	o the cause(s)
	To the within 2.	Me	255. Signature dry 199 specialist	c. License number		9d. Date signed (Month,	
	801		Nam mi)	D0055120		JANUARY Y	2007
,	(2)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			A	
_	THE		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Palmer MD 1328 Son Lem Avenue SE Sm. R	310 Was hing	ball re	D\$2	
* 1	Sta		31. Date filed (Month, Day, Year) 32. Hegistrar's Signature	7			
	Registi	ar	JAN 1 0 2007 Page 1 Second				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MARGARET ELIZABETH HENCH January 4, 2007 6:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
August 5,1920 9. Birthplace (State or Foreign Country) VA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛣 F 231-12-1471 Director 86 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10401 Grosvenor Place #428 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify. þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rev. N.C. Turner Mary Powell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loris Patterson (Sister) 10401 Grosvenor Place #1122 Rockville, Md. 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 8. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify)Intombment Ft. Hill Mem. Pk. Lynchburg, VA 2007 ure of Funeyal Service License 22. Name and Address of Facility DeVol Funeral Home uctio 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician Emphysema Years /Medical Due to (or as a consequence of): Examiner Hypertension Years Sequentially list conditions, if any, leading to immediate cause. Enter programs Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Osteoporosis Years Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month Dav Year 5 Other (specify) Division or Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy med? 2X No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2No this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation To the Hospnar.

within 24 hours after death.

To the Funeral Director: After the Funeral Director of the funeral Director of the funeral of the funeral part of the funeral part of the funeral of the f 1 X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35792

State Registrar

Day, Year) 05 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Swaroop Rao M.D.

31. Date filed (Month

gistrar's Signature

50 West Edmonston Dr. Rockville, Md. 20850

January 4, 2007

07-00098 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James F. Hughson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle Last) 2. Date of Death Physician/ **Medical Examiner** 1127 hrs January 4, 2007 James Francis Hughson 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 2620 Meadowsweet Drive Waldorf Charles 5 Social Security Number If Under If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Age (In yrs last birthday 1 Year Months Min Foreign New York Davs Hours Director 139-40-5158 1 X M 2 59 Yrs 06/04/1947 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d Inside City Limits 23a or 28a-f show notified at once. Yes 2 X No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 运 2620 Meadowsweet Drive 20601 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black. Armed Forces? Never Married 2 Married 1 X Yes Yes, Give Year Widowed Specify White 4 X Divorced 1 Yes 2X No specify "natural", ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than 21215-0036 12 Service/Parts Director Automotive 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) the Be Francis A. Hughson, Sr. Alice K. Sommers 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 shunent of Health and 27315 Birchmanor Circle, Mechanicsville, MD 20659 Matthew S. Hughson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State mportant; Huntt Crematory 01-06-2007 Waldorf, Maryland Donation 5 Other Specify F Signature of Funeral Service Licensee 22. Name and Address of Facility M01391 3035 01d Washington Road <u>Funeral Home</u> Waldorf, art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval failure List only one cause on each line. Between Onset and /Medical Death a Intra-oral Gunshot wound Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of). Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED ending physician use as the burial -AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months' Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 ✓ Yes No To the Hospital or Attending Physician: 25 Was case referred to medica 26 Place of Death (Check only one) Be Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✓ Other Scene 1 🗸 Yes 28a. Date of Injury FOUND: Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Subject shot self FOUND: Natural Pending Yes 2 V No To the Funeral Director: Jan 4, 2007 1127 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be 2620 Meadowsweet Drive, Waldorf, MD (Specify) Single Family Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

DB781

OCME 2006

Registrar DHMH 17 Rev 1/2001

State

Susan Hogan MD.

31. Date filed (Month Par Yen) 8

and manner stated.

ess of person who completed dause of death (Item 23a)

Assistant Medical Examiner

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 5, 2007

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pembradic Square Suite 504 Margher

			1 - For State Registrer	State o	f Maryla	nd / Depa		of H	ealth a				-		597
	Physici	an	Decedent's Name (First, Middle, La	ist)							2. Date of Dea Month	ath Day	Year	3. Time o	f Death
	/Medio		Robert G. Hulka								January		2007	1:30	РМ
	Examir	ier	4a. Facility Name (If not institution, give		nber)				Location of	f Death		1	County of Death	1	
			Joseph Richey Hos  5. Social Security Number 6.5	-	7. Ago //g us	a last hirthday	Ball If Under 1	tim	ore If Under 2	DA Hrs	O Date of Birth		/A	-1. (0)	
	Funeral Director			1 <b>∑</b> M 2□F	63	s. last birthday) Yrs.		Days	Hours	Min.	8. Date of Birti (Month, Day 4/2/194	Year)	Col	place (State intry) York	or Foreign
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an	d be ental	To Be	Paul Hulka							ty Ko			30771277707		
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	and 2 selth a 27 is		Barbara G. Hulka,	/wife									ville,		104
Baltimore,	es 1 an of Heel f item 2 r other		20a. Method of Disposition	<b>x</b>		Place of Dispo	sition (Name	e of	ı İ	D	ate	20c. Loc	ation - City or T	own, State	
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68760,	Physician /Medical Examiner	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (	or as a conse	quence of):	(a)	Ce	reb	ral				Onset and Onset and	Death
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<b>√</b>	Physicien: this certific ral director,	္ရ	1 □ Yes 25-No			ER/Outpatien			4 LI Nurs	sing Hom	e 5 ☐ Reside	ence 6	Other (Speci	W Hose	ice
n O	nding Physicien: ith. After this certifics funeral director, is	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		of Injury h, Day Year)	28b. Time of Injury		c. Injury Work?			8d. Describe ho	ow injury	occurred		
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7	0,00		30. Name and address of person who	completed cause	e of death (Ite	m 23a) (Type, I	Print)	~/				-4	1/-/		
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	Physici	an	1. Decedent's Name (First, Middle, Last PATRICIA	)				+11	CKS		2. Date of D Month	Da	-		3. Time of Death
	/Medic Examir		4a. Fecility Name (If not institution, give	street and number)			4b. Cit	, Town, or			JANUARY		. County of D		3 / "
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Ь	Funeral Director		250-00-1100	x	6 (In yrs. I	ast birthday) Yrs.	Months	or 1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D Aug	rth a <i>y, Year)</i> 3, 1950	9.	Birthple Counti Sout	h Carolina
	ehow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					-		10	d. Inside City Limits
	e Man	ctor	MD Calv	/ert				Pr	ince Fr	edericl	k				1 ☐ Yes 2 🖔 No
	h with th	al Dire	10e. Street and Number 1105 Dares Beach Road				10f. Z	ip Code	2067	8		10g. Cit	izen of What U.	Count S.A.	ry?
980	be filed within 72 hours after deeth with the Maryland ital Hygiene.  d other then "neturel", or Iteme 23e or 28e-f ehow event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates:			Yes, sp	edent of Hi ecify Cuba 2 No	spanic Ori , Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, W Specify: B	/hite, e	
2-0	netur	eted	15. Decedent's Edu (Specify only highest grad			16a. Deced	kind of w	ork done d	uring most	t of worki	ng	16b. K	ind of Busine	ss/Indu	ustry
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and	should be filed and Mental Hygin marked other imatic event, t	To Be C	17. Father's Name (First, Middle, Last)	Martin Dowl	ing				18. Mothe	r's Name	(First, Middle		Sumame) e Wright		
Maryland	d 2 s th ar 17 le treu	F	19a. Informant's Name/Relationship (7) Marcia Kent /Daughter	rpe, Print)			•				I Route Numb			в, <i>Zip</i> (	Code)
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or other tu	3	20a. Method of Disposition 1 ☐ Burial 2 🗡 Cremation 3 👺 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	20b. P!	ace of Dispo emetery, cren Metropoli	natory or	other place	9)		Pate 06/07	ocation - City or Town, State  Alexandria, VA			
Baltir	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens  ### ### ############################				. Name a	and Addres		lome	ad Prince	Erodo			
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68760,	icate be executed physicien and the burial-transit	al Examiner	that initiated events resulting in death) Last	Due to (or as		RENA	<u> </u>			****					
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	quires tha n signed I ald be det	۵	Part II. Other significant conditions con	ntributing to death b	ut not resu	lting in the ur	derlying	cause give	n in Part I.			tobacco u Yes 2			cause of death?
Division of Vital Records,	Physician: The law requires that the this certificate has been signed by the rat director, page 2 should be detache	Completed									24a. Whas auto perfo 1 ☐ Yes		prior	to comp	sy findings available pletion of cause of
Vit.	sician: Th certificate lirector, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	nt 2 🗆	ER/Outpatien	20.5	Othe	^		(Check only		0 1704 /0		
on of	After Iune	tlon: To	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28b. Time of Injury	3 🗆 🗆	28c. Injury Work	4 [ 140	2	ne 5 Resi			pecity)			
Divisi	el or Attending s after death. il Director: After id in by the fune	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At hor c. (Specify)	me, farm, stre					28f. Location ( City or To	Street an wn, State	d Number or )	Rural	Route Number,
	To the Hospital or within 24 hours after To the Funaral Direcompletely filled in b	edical C	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exami	sician: To the best ner: On the basis of and manner sta	f examinati	vledge, death ion and/or inv	occurre	d at the time n, in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and manner I place, and c	as stat	ted. he cause(s)
	To t. To ti	M	29b. Signature and title of certifier	MD			25	c. License		4			e signed (Mo		*
	5		30. Name and address of person who co		eath (Item	23a) (Type, I	Print)	-	- 000			_	BALTIA		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  CLCAY AKSO1, THE JOHN'S HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAN  21257  31. Date filed (Month, Day, Year)  32. Registras Signature  1AN 0 8 2007 Marylan  Appells								21257				
3	Sta Registr	_	IDN 0 8	3 2007 ▶	Police.	, K	Do	de							

07-00360 Francis Delano Jones

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

- Dlaii		Registrar 1. Decedent's Name (First, Middl	e Last)	Cerun	cate of	Deall		10	Re . Date of Deat	ng No	3. Time of Death	
Physicia ledical Exami		Francis	Delar	10		es, Jr			Month January 1	Day Year 2, 2007	1850 hrs	
FIATA		4a. Facility Name (if not institutio Memorial Hospital	n, give street and number)		41	b. City, Town, Cumberla		of Death		4c. County of Allegany	Death	
Funeral Director		5. Social Security Number 578-68-8672		(In yrs, last b	irthday)	If Under 1 Y Months D	ear If Und	er 24Hrs Min.			9 8 irthplace (State or Foreign	
Director	ŀ	Usual Residence of Decedent	1 X M 2 F	55	Yrs.				12/30/	1951	Country) D.C.	
w any	Ī	10a. State 10b. County MD A1	legany	10c, City, Tow		on umberla	and				10d Inside City Limits 1 Yes 2 X No	
daryland 28a-f show	Director	10e. Street and Number	.iogany			10f. Zip Code			10	Og Citizen of Wha		
th the M 23a or 2 notified			ridge Road,				21502			USA		
leath wi	Funeral	11. Marital Status  1 Never Married 2 X M	arried 12. Was Decedent Armed Forces? 1 X Yes 2	Ever in U.S.		Decedent of I			cify Yes or No- ican, etc.)	14 Race - White,	American Indian, 8lack, etc.	
s after d rral", or	百	3 Widowed 4 Div	orced If Yes, Give 1972-1	981		Yes 2 X I			rk dono	Specify 16b Kind of 8us	Black	
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	dmo:	17. Father's Name (First, Middle,	Last)			-	_			Maiden Surname)	- Institution	
1215 I be filed ental Hy arked of	Be	Francis										
Baltimore, MD 21215-0036  premit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Sel and a should be give with 72 hours after death with the Maryland Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	2		informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1801 Williamsburgh Court, Ft. Washington, MD 207									
Baltimore, MD bernit Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati		20a Method of Disposition  1 X 8urial 2 Cremation	n 3 Removal from Sta		of Disposil atory or oth	tion (Name of er place)	cemetery,		Date	20c. Location - (	City or Town, State	
Itimo it Page irment ortant:		Donation 5 Other Specify. MD Veterans Cemetery 01/24/2007 Cheltenham, MD Schopture of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home										
Ba perm Depa Impo		Kalut C Al	22. Name and Address of Facility Adams Family Funeral Home, P 404 Decatur Street, Cumberland, MD 21502									
Physician /Medical	1	23a. Part I. Enter the disease, or failure. List only one cause	on each line.							est, shock, or hear	Approximate Interval 8etween Onset and Death	
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68760, certificate be adding physicial se as the burial section set as the section set as the section section section section set as the section	an/Medical	IF FEMALE: 23b. Was decedent pregnant in the	AMENDED #12 23c. If yes, outcor	,16a-b, pregnand	У					23d Date of c	delivery	
Aecords, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri	ician	past 12 months?	4 Pregnant at	time of death	2 Feta 5 Oth	al death : er (Specify)	BEctopi	c pregnan	су	Month	Day Year	
). Box the death of by the attentiched for us	Physici	Part II. Other significant condit	9 Officiowit	n but not result	ing in the ur	nderlying caus	e given in P	art I	23e Did to	bacco use contrib	oute to the cause of death?	
<b>P.O.</b> irres that the signed by	2								1 Yes	2 No 3	Probably 4 Unknown	
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Vital Reco visician: The law his certificate has director, page 2 s												
Vita Vita hysicial this cer	o Be	O 1 Yes 2 No 1 Inpatient 2 Y ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other:										
Division of Vital Records, within 2-hospital or Attending Physician: The law requir within 2-hours after death. To the Funeral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should be	ion: T	27. Manner of Death  1 X Natural 5 Pend	28a. Date of Inju (Month, Day,Y	ry 28k ear)	. Time of In	ijury 28c. Ir	ijury at Worl		8d Describe h	now injury occurre	d	
ivisior or Attend after death Director:	Certification:	2 Accident Inve	stigation 28e. Place of In	jury - At home,	farm, stree	t, factory, offic	e building, e	tc. 2	8f. Location (S		or Rural Route Number. City	
Divis Hospital or At 24 hours after d Funeral Direct		4 Homicide dete	rmined (Specify)									
D To the Hospital Within 24 hours To the Funeral completely fillee	Medical	(Check only Certifying P	hysician: To the best of m miner:On the basis of exa and manner stated									
I % I S	Me	29b Signature and title of certific					nse number	-			(Month, Day, Year)	
		30. Name and address of person	hall, MA) who completed cause of o	eath (Item 23a	<u> </u>		J.IVI.L.			January 14,	2007	
Ø	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
s	tate	31 Date filed (Month Day Xear)	2007 32 Registra	r's Signature	13000	Cind of the last						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 5:15 PM LEOMA JONES KRUZIC JANUARY 3, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL STLVER SPRING MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🖾 F Yrs FEBRUARY 9, 1922 Director 245-20-9828 84 VIRGINIA Usuat Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or Items 23a or 28a-f show the Medical Examiner must be notified at 1 TYes 2 X No MARYLAND MONTGOMERY SILVER SPRING Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10317 LARISTON LANE 20903 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No à Specify Specify: 3 XWidowed 4 Divorced WHITE "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Importent: If Item 27 is marked other than "ns any injury or other traumatic event, the Maute once. Elementary/Secondary (0-12) College (1-4or 5+) EDITOR DEPARTMENT OF AGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LAMUEL JONES UNA TUNNELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS D. KRUZIC - SON 10515 ROLLING GREEN COURT, CLARKSBURG, MARYLAND 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) GATE OF HEAVEN CEMETERY 1/8/2007 SILVER SPRING, MARYLAND 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Jacens 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or pearl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC COLON CANCER /Medical Due to (or as a consequence of) Examiner BILATERAL BREAST CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physicien are s the burial-t Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 1 I ive hirth 2 Fetal death in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ HYPONATREMIA should t 1 Tes 2 No 3 ☐ Probably 4 ∑Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? DEHYDRATION has e 2 autopsy performed? page 2 No 1 Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 🖾 Inpatient 2 ER/Outpatient 3 DOA SIU 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. investigation М 1 TYes 2 TNo 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of contribution 29c. License number 29d. Date signed (Month, Day, Year) Ó DK 9758876 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. KAPOOR, M.D., HOLY CROSS HOSPITAL, 1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND 20910 31. Date filed (Month, Day, Year)

JAN 0 8 2007 Registrar's Signature State Registrar

		For State Registrar	State of Maryland		artment of F rtificate of			giene Reg. Ne () ()	7 01601
Physiciai /Medica		1. Decedent's Name (First, Middle, Last) $Allen \\$	Katz				2. Date of De January		3. Time of Death 10:15 A M
Examine  Funeral  Director	r	4a. Facility Name (If not institution, give str 6726 25th Avenue 5. Social Security Number 6. Sex 1 Name 1 1 Name 1 1 Name 1 Nam	eet and number)  7. Age (In yrs. le		4b. City, Town, o  W. Hyat  If Under 1 Year  Months Days		8. Date of Birl	th (	Death  e Georges  B. Birthplace (State or Foreign Country) Wash. D. C.
TO	_	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
h with the Mi 3a or 28a-f	al Director	Maryland Prince Ge 10e. Street and Number 6726 25th Avenue	eorges Wes	t Hyat	10f. Zip Code	782		10g. Citizen of Wh	at Country?
al",o	by runeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S Armed Forces? 1 Ayes 2 No Ar If Yes, Give Year or Dates: Kore	шу	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
within 72 ho giene. r than "natur the Medical."	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired Lawyer	pation during most of wo d)	rking	16b. Kind of Busin	,
Mental Hyg wrked othe artic event,	o pe o	17. Father's Name ( <i>First, Middle, Last</i> )  Morris Katz					me (First, Middle, ne Rubin	Maiden Surname) L	
and 2 sho ealth and I n 27 Is ma ier trauma		19a. Informant's Name/Relationship (Type Philip Katz — Broth	ner	13826	Flint R		, Rockvi		yland 20853
Pages 1 ment of Hi tant: If Iter lury or oth		20a. Method of Disposition  1	noval from State	metery, crei ean Me	esition (Name of matory or other place)  em. Garde	ns Jan.	8, 2007	01ney,	ty or Town, State Maryland
Deprit Import any In		21. Signature of Funeral Service Licensee		Eq. 10		el Funer ille Pik		tion, In	
Physician /Medical		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death cause on each line.  Ha	scup	er the mode of dyii	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death Months
Examiner	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classoc or Injury that initiated events	Due to (or as a consequence)						
ficate be executed physician and is the burial-transit	edical Examin	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
The law requires that the death certificate has been signed by the attending phyage 2 should be detached for use as the	iysiciali/linedi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t. If yes, outcome pf pregnar 1□Live birth 2□Fetal- 4□Pregnant at time of de 9□Unknown	death 3	Ectopic pregnanc	/		23d. Date of Month	,
w requires that been signed be should be deta	2	Part II. Other significant conditions contri	buting to death but not resul	ting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?  Probably 4 Unknown
i: The law requicate has been r, page 2 should	combiered						24a. Was autop perfo 1∐ Yes	an 24b. We ssy pric rmed? dea 2 X No 1	ere autopsy findings available or to completion of cause of ath? ]Yes 2  No
sician certifi irector		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	spital: 1 □ Inpatient 2 □ E	D/Outnation	t all DOA Oth	ar.	ath (Check only o		
Physer this ceral dir		27. Manner of Death	28a. Date of Injury	28b. Time of	N 3LI DOA	4 Li Nursing F		lence 6 Other	· · · · · · · · · · · · · · · · · · ·
ital or Attending F rs after death. ral Director: After led in by the funera	IICALIO	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year)  28e. Place of injury - At hor building, etc. (Specify)	Injury ne, farm, str	M 1□	k? Yes 2∐No	28f. Location (S City or Tow	Street and Number	or Rural Route Number,
		29a. Certifier 1 X Certifying Physic	lan: To the best of my know	rledge, deatl	h occurred at the til	me, date and place	e, and due to the	cause(s) and mann	ner as stated.
the Hosp ithin 24 hou the Fune ompletely fi	200	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (	
F 3 F 8		)				089		January	
, -		30. Name and address of person who com Dr. Michael Leibox				tomac M	d. 2085/		
State		31. Date filed (Month, Day, Year)	32 Registrar's Signatu		20110 10	comac, Fi	4. 20054		

			for State Registrar	State of N		nd / Depa		of H	lealth and M	lental Hy		007	01602
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	er dee Iteme	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	J.S. 13.	Was Decede If Yes, spec	ent of H rfy Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. F	Race - Ameri Black, White	
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lan	nd 2 should be fi lith and Mentel H 27 Is marked of r traumatic ever		19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street	and Number or Run	al Route Numbe	er, City or To	wn, State, Zi	p Code)
≥ ~	of Heelth Item 27		Laura Kamer-Isra	el /Daugh					ield Dr.	Potoma			
ore	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 Note: 1 Description 2 ☐ Cremation 3 (	Removal from Sta		Place of Dispo			(e)			on - City or T	
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Baltimore, Maryland 21215-0036	permit. Pages Depertment of Important: If I any Injury or once.		21. Signature of Funeral Service Lice			Da Ro	anzans	ky-	ss of Facility Go1dberg - Md - 2085	1170 R		lle Pi	ke
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				600 01d G				thes	da. Md. 2	20814	i (		
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Lester William Lo			elible Ink. Ensure All Copi ment of Health and Mental H ficate of Death	<b>es Are Legi</b> lygiene	ble.	7 0160
Physicia	_	Registrar  1. Decedent's Name (First, Middle,Last)		Reg. 2. Date of Death	. No.	3. Time of Death
Medical Examin	ner		iam Lookingbill	January 16,		1140 hrs
		Facility Name (if not institution, give street and number)     Washington County Hospital	4b. City, Town, or Location of Deat  Hagerstown	h	4c. County of Death Washington	1
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ow any			wn or Location			10d Inside City Limits
ryland a-f sh	횽	Maryland Washington 10e Street and Number	Sharpsburg 10f. Zip Code	100	. Citizen of What Cour	1 Yes 2 X No
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	18516 Mt. Lock Hill Road	21782	109		,
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5-0036 iled within 72 Hygiene. I other than the Medical	ď	2	Mail Handler		U.S. Posta	al Service
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2121 uld be fi Mental ] marked c event,	To Be	Aubrey Austin Lookingbill  19a Informant's Name/Relationship (Type Print)	19b. Mailing Address (Street and Number or	Maria Wat Rural Route Numbe		Zin Codo)
MD rd 2 sho llth and m 27 is		Elizabeth Ann Lookingbill (Wife)				
re, l I and FHeald If item	1		ce of Disposition (Name of cemetery, natory or other place)		20c. Location - City or	Town, State
Baltimore, permit Pages I ar Department of Hee Important: If ite		Tomover non otate	thsburg Crematory	nuary 19 2007	Smithsburg	, Maryland
Salti ermit Pepartr mport njury	Ī	21. Signature of Funeral Service Licensee	22. Name and Address of Facility		is Funeral	
Physician	=	23a. Part I. Enter the disease, or complications that caused the death. Do	12525 Bradbury Ave	e. Smiths	burg, Mary	land 21783 Approximate Interval
/Medical Examiner	Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ndiovascular disease			Between Onset and Death
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Division of Vital Records, Find or Attending Physician: The law requires rafter death al Director: After this certificate has been sign then by the funeral director, page 2 should be	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of s 2 No
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Di To the Hospital within 24 hours : To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, one)  2 Medical Examiner: On the basis of examination and/of and manner effect.	death occurred at the time, date and place, and or investigation, in my opinion, death occurred a	I due to the cause(s at the time, date and	and manner as state place, and due to the	d cause(s)
F 3 F 8	Me	29b Signature and title of continer	29c. License number O.C.M.E.		9d Date signed (Mon	
	ŀ	30. Name and address of person who completed cause of death (Item 23a				
Ф			111 Penn Street, Baltimore, MD 21	201		
Sta Registr		31 Date filed (Month, Day, Year) 22. Registrar's Signature	Sports.			

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		1 _ For State	State of Maryl				Mental Hy	giene	17 016	504
		* Registrar		Cen	ificate of	Death		Reg. No.	7 7 0 1 (	5 0 7
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Fune Direct		055-16-2530	1 M 2 MF	Yrs.	Months Days		8. Date of Birt (Month, Da	y, Year)	9. Birthplace (State of Country) Massachu	
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Maryland -f show		10a. State 10b. County	100.	: City, Town or Loc	ation				10d. Inside C	ity Limits 2  No
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er de	1 8	11. Marital Status	12. Was Decedent Ever in Armed Forces?	in U.S. 13. W	as Decedent of I Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	Rican, etc.)	Black	- American Indian, , White, etc.	
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lore, Maryla ges 1 and 2 should t of Heelth and Men if item 27 is marke		19a. Informant's Name/Relations	nip (Type, Print)	19b. Mailing	Address (Street	t and Number or Ru	ral Route Numbe	er, City or Town, S		
		David	Lane	500	SiMa	in Stre	Date HUI	rlockn	Oryland a	11643
Peges 1 Peges 1 Int: If its		20a. Method of Disposition  1   Burial 2   Cremation		Db. Place of Disposi cemetery, crema	atory or other pla	1 1				, 1
altim nit. Pe partmen cortant;		4 Donation 5 Other (S		1idShore	Crema	/	107		dge, Mary	land
Baltimore, permit. Peges 1 ar Department of Hee Important: if Itam	once	21. Signature of Funeral Service	C 24	Ind a	Name and Addre	uneral H	bome, P. A	2.	110 01	(12
403	4	23a. Parti Enter the disease, or	complications that caused the	5		N. 10010	31/ 6//	VI PY I GUALC	Approximat	613
		shock, or heart failure. List	onty one cause on each line.	doan. Do not enter	the mode or dyr	ing, such as cardiac	or respiratory ar	1031,	Interval Bet Onset and	tween
Physici /Medic		disease or condition resulting in death)	a. Old a	ge						
Examin			Due to (or as a con	nsequence of):						
	<b>a</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a con	nsequence of):						
uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>.</b>							
760, te be executed ysiclen and e burial-transit	E K	resulting in death) Last	Due to (or as a con	nsequence of):						
760 te be e ysiclen	8									
Box 687 leath certificate attending phys	by Physician/Medi	Is service								
BOX eath cert attendin	Vue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Ectopic pregnanc	cy .		23d. Date Mont	of delivery	Year
O. En the deal the at	10	in the past 12 months?	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify) _			WOI	n Day	Tour
IS, P.O. I res thet the de signed by the a	4	9 Unknown Part II. Other significant condition	One contributing to death but not	t reculting in the unc	faching course on	upo in Part I	23a Did to	phaceo use contoh	oute to the cause of o	death?
Records, P.O. Box 68 The law requires thet the death certificat stehes been signed by the attending phy about 2 should be detached for use as in	2	Part II. Other significant conduct	The contributing to death but not	r resulting in the tind	ienying cause gr	VOITIN F QUEL.			B Probably 4 🗆	
Cord: w require been sig	Completed		-							
Aec e law hes t	1 1 10						24a. Was autop	an 24b. w osy pr rmegel? de	ere autopsy findings for to completion of c eath?	available ause of
Vital F Vician; Th Certificete	ع ا						1 Tes	20 No 1	Yes 2□ No	
r Vital Re ysician; The lis certificete he director, page	B	examiner?	Hospital:	2 ER/Outpatient	ou con Ott	26. Place of Dear		ine) dence 6 ∐Othei	(04)	
Physic replies	.   -		28a. Date of Injury	28b. Time of	3□ DOA 28c. Inju			now injury occurre		
On of oding Phy th. : After thi	2	1 Natural 5 Pendin 2 Accident investig		er) Injury		ork? ]Yes 2 □No				
DIVISION Of VITAL RECORDS,  I or Attending Physician; The law requires tater death. Director: Alter this certificate has been signed in by the funeral director page 2 should be a	, j	3 Suicide 6 Could r 4 Homicide determ		At home, farm, stree	et, factory, office		28f. Location (S City or Tox		r or Rural Route Nurr	ıber,
Div	Certification	a Homoda	building, etc. (5)	эвспу)			Ony or Ton	m. Statey		
DIVISION To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Polical	29a. Certifier Certifyin	g Physician: To the best of my Examiner: On the basis of exam	knowledge, death	occurred at the ti	ime, date and place,	and due to the	cause(s) and man	ner as stated.	s)
the H in 24 the F	1	one)	and manner stated.							,,
ToT	×	29b. Signature and title of certified	A/)		29c. Licens	se number		290. Date signed	(Month, Day, Year)	
		skyland	or No		1400	05997	3	1/5/0	7	
		30. Name and address of person	11 -		//	10 St	reet (	Tambri	doc MX	21613
	State	31. Date filed (Month, Day, Year)	JOHNSON D		10 ram h	JE WII	eer (	wirth.	age, MD	2145
Reg	State Jistrar	IAN	0 8 2007 \ Kee	w K	Sparte )					

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Franklin ne Jan 2007 8:03 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare -The Pines Easton Talbot If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 ☐ F 218-24-5129 Usual Residence of Decedent 86 Feb. 10, 1920 Director Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, it a Modical Examinar must be notified at 1 PYes 2 □ No MD Funeral Director Talbot Laston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. BOX 284-Coppersville USA 10162 601 death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. hther than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married John Lane Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ₩idowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 Operator roduce Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental Health if I tam 27 is marked officery or other traumatic even Be ဂ Charolette T. Lane John Lockerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Bellevue Rd. P. O. Box 284 Royal Oak, MD. 68 2 Edna Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of important: if any injury or once. Coppersville Cometery 4 ☐ Donation 5 ☐ Other (Specify) Easton Maryland 22. Name and Address of Facility Henry Funeral Home, P. A. Sio Washington St. Cambridge 21. Signature of Funeral Service Licensee 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** umi ears resulting in death) /Medical as a consequence of): Due to (of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and is the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? (es 2/2/No 1 Yes Division of Vital To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ို 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 Matural death. 1 Yes 2 No 2 Accident 24 hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Serifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of cegifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of se of death (Item 23a) (Type, Print) State Registrar

07-00022 Todd D. Lubin

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar AMFND#22000FH	11/8/07.BMW.Mc	Con	tificate of			, ,	eg No. 201	07 0160
Physicia Medical Exami		Decedent's Name (First, Middl     TODD DANIEL LU						2. Date of Dea Month January 1		3. Time of Death 1655 hrs
many		4a Facility Name (if not institution		∋r)	4	b. City, Town, o	r Location of Dea	January 1	4c. County of De	
		Fulks Farm E. Village	Lane			Olney			Montgomer	
Funeral Director		5. Social Security Number 220-06-9402	6. Sex 7.7	Age (In yrs. Ia 23		If Under 1 Yes		1 8 Date of Bu	/1983	Birthplace (State or reign Country) MD
, i		Usual Residence of Decedent  10a State 10b. County		10a City	Town or Location					
1 aryland 28a-f show any	_	,	TGOMERY	Toc. City,	TOWN OF LOCATIO		DLNEY			10d. Inside City Limits 1 X Yes 2 No
farylan 28a-f s at on	Director	10e. Street and Number	TOOTIBILE		<del>- 1</del>	10t. Zip Code	DIVET	1	0g. Citizen of What C	
215-0036  be filed within 72 hours after death with the Maryland nutal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	al Dir	3832 WILBERTA	STREET  12. Was Decede	nt Ever in U.S	13 10/25	Decedent of H	20832	Specify Yes or No		J.S.A.
death v or item: must be	Funeral	1 X Never Married 2 Ma	arried Armed Force			s, specify Cuba	n, Mexican, Puer	to Rican, etc.)	White, etc	nerican Indian, Black, :.
rs after ıral",	by	3 Widowed 4 Divi	orced If Yes, Give Year or Dates:			Yes 2 X No			Specify:	WHITE
2 hour	eted	Elementary/Secondary (0-12)	College (1-4 o		during mo	s Usual Occupa st of working life	ation (Give kind o	of work done etired)	16b. Kind of Busine	ss/Industry
5-0036 led within 72 hours after Hygiene. t other than "natural", the Medical Examiner.	Completed		1		AS	SISTANT	MANAGE			INGRAVING
MD 21215-0031 d 2 should be filed within th and Mental Hygiene. n 27 is marked other tha	Be C	17. Father's Name (First, Middle, CHARLES S. LUB	,					me (First, Middle, I		-
2 5 6 5 5	To	19a. Informant's Name/Relations							nber, City or Town, St	ate, Zip Code)
		CHARLES AND LII	NDA LUBIN-P.	ARENTS	3832 W lace of Disposit	ILBERTA	STREET	, OLNEY,	MARYLAND 20c. Location - City	20832
of F		1 X Burial 2 Cremation		State Cr	ematory or other	er place)				
Baltimore, permit Pages I ar Department of Hee Important: If itei		4 Donation 5 Other Sp 21 Signature of Funeral Service		JUD	EAN MEM	ORIAL G	DNS 01	/05/2007 and Sage	OLNEY, MA	RYLAND Direction, INC , INC.
Per Deg		Clyn			1109	1 ROCK V	LLLE PT	KE. ROCK	VII.I.F. MAR	; INC. YLAND 20852
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.		Do not enter the	mode of dying	, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Head & Neck		1			<del></del>	<u> </u>	Death
Marine of the Control	<u>.</u>	Sequentially list conditions,	b							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a con	isequence of)						
ecuted and - transit		events resulting in death) Last	Due to (or as a con	sequence of)						
ial ial	/Medical	UNPENDED	AMENDED							
68760, certificate bo nding physic se as the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	ome of pregna	,	I death 3	Ectopic pregi	nancv	23d Date of deliv	ery Day Year
Box 68  • death certif  the attending ed for use as	Physician	past 12 months?  1 Yes 2 No 9 Unk	nown I	at time of dea	th -	er (Specify)			III	Day 16ai
that the denoted by the	Phy	Part II. Other significant condition	9 Olikilowii	ath but not res	sulting in the un	derlying cause	given in Part I.	23e Did to	bacco use contribute	to the cause of death?
- N 20 0	d by					_				robably 4 Unknown
ords, w requir	Completed by							24a Was a		autopsy findings available o completion of cause of
Rec( The la icate ha	Juo.		***					perfor	med? death	?
ital Re- ician: The s certificate rector, page	Be	25. Was case referred to medical examiner?	Hospital:				Other Nurs			
1 of Vi ting Physi After this funeral dir	٦.	1 ✓ Yes 2 No 27. Manner of Death	28a, Date of In	jury :	R/Outpatient 28b. Time of Inj		Iry at Work?		Residence 6 V Oth	ner: Scene
ion (tending eath tor: All the fur	ation	1 Natural 5 Pendi 2 V Accident Inves	(Month Day	,Year)	1636 hrs	,,,,,,,	Yes 2 V No		o involved in col	lision
Division of Vital Records, pital or Attending Physician: The law require ours after death eral Director: After this certificate has been sittled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could	d not be 28e. Place of i		ne, farm, street,	factory, office t	outlding, etc.	or Town St	tate)	Rural Route Number, City
ig spi	- 1	4 Homicide	nysician: To the best of r			d at the time d	oto and place and	Fulks Farm Ro	d & East Village Av	
Division of Vital Division of Vital Within 24 hours after death  To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical	(Check only one) 2 Medical Exan	miner: On the basis of example stated	amination and	d/or investigatio	n, in my opinior	ate and place, an n, death occurred	at the time, date a	e(s) and manner as st and place, and due to	ated the cause(s)
	Σ	29b Signature and title of certifier	1 11	-		29c Licens			29d Date signed (A	
		30 Name and ordered	VI. LE	do allo di si in a	22-1	O.C.	IVI.⊨. 		January 2, 200	/
_		30. Name and address of person value. Dept	who completed cause of uty Chief Medical E			Street, Bal	timore, MD 2	1201		
St: Regist	ate rar	31. Date filed Month, Edy, Sear 2	007 Registr	ar's Signature	Coarte	9				
	_									

			1 - For State Registrar	State of I	Marylar	nd / Depa	artmer <i>rtificat</i>	t of H	lealth a Death	and M	lental Hy	giene Reg. No.	200	7	01	607
	Physic		1. Decedent's Name (First, Middle, La MAGGIE	S.	LOTT						2. Date of De Month	Day O	7 ž(	ეზ7		of Death
	/Medi Examir		4a. Facility Name (If not institution, gir Southern Mary					Town, or	Location of	of Death		4c.	County of C	Death		• 2 11.1
	Funeral Director			Sex 7 1□M 2只F	Age (In yrs. 89	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 09-16	th ly, Year) -1917	9. 7 <i>I</i>	Birthpli Count Lab	ace (State ry) ama	e or Foreign
	e Maryland ta-f show	ctor	10a. State 10b. County	Georges		ty, Town or Lo rattsvi								10		City Limits
	h with th	al Dire	10e. Street and Number 6440 Sargent Roa	nd			10f. Zip	Code 2078	2			10g. Citi	zen of Wha	t Count	ry?	
9000	be filed within 72 hours after death with the Maryland hat Hyglene. If other then "naturel", or iteme 23a or 28a-f show event. I're Medical Examinat remait he notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	s? No		Was Decedif Yes, spe		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		14. Race - / Black, V Specify: I	Vhite, e	itc.	
Maryland 21215-0036	12 should be filed within 72 h h and Mental Hygiene. 7 ie marked other then "nati raumatic event, tre Medic	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed)  4 College (1-4c	or 5+)		dent's Usu- kind of wo DO NOT u cher	al Occupa rk done d se retired	during most			GOT	nd of Busin		ustry	
ryland	nould be fi d Mental H narked ot natic ever	To Be	17. Father's Name (First, Middle, Last Clifton Gooch	1					Elm	nira	(First, Middle Drap	er				
			19a. Informant's Name/Relationship Bernard Lott	Son		3401	Navy	Day		æ, s	Buitlan	d, MI	2074	16		
Baltimore,	permit. Pages 1 and Department of Heall important: if itsm 2 any injury or other <u>9008</u> .		20a. Method of Disposition  1 □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□		te Ce	Place of Dispo cemetery, crer edar Hi	natory or o	ne of other place emete	ery	01/1	2/2007		cation - City tland			
Ball	permit Depart import any in		21. Signature of Funeral Serv	hsee M					s of Facility		st NW	Wash	n, DC	200	11	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Acu		YOCA					TO N	rrest,			Approxim Interval B Onset an	etween
8760,	cate be executed oblysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	as a conseq			-Miges	tel .							-
P.O. Box 6	The law requires that the death certific ate hes been signed by the ettending places 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	I death 3	Ectopic pr					2	3d. Date of Month		y Day	Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions		but not res	ulting in the u	nderlying c	ause give	n in Part I.			obacco us	se contribut	e to the		death? Unknown
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Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hamital				100		of Death	Check only o	пе				
of	nys dir	2	1 Yes 2 No 27. Manner of Death	Hospital:		ER/Outpatien			4 LINUI		ne 5 ☐ Resid			Specify)		
sion (	ding h. After fune	Certification:	1  Natural 5  Pending 2  Accident investigation		gury Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🗀 Y	at ? ′es 2 □ N		28d. Describe l	now injury	occurred			
DIVI	Dig att	Certifi	4' ☐ Homicide determined	building,	etc. (Specif	y) 					28f. Location (3 City or Tou	vn, State)				mber,
	To the Hospitei within 24 hours a To the Funerel I completely filled	edical	29a. Certifier  (Check only one)  1	nysician: To the bearings: On the basis and manner	of examina	wledge, death tion and/or inv	occurred restigation	at the tim in my op	e, date and inion, deat	d place, a h occurre	ed at the time,	date and	place, and	due to t	he cause	(s)
	To To con	Σ	29b. Signature and title of certifier				290	D 4	number 0324	į			signed (MUAR)			7
	H 5		30. Name and address of person who TERM JOD RIE	M.D. 7	103 S	URRATT-	S Ro	HÒ,	CLIN	NOTU	MARI					
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	Coarte	,									

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artmen ertificat					iene	. 01608	7		
	°		1. Decedent's Name (First, Middle, Las	")			·			ate of Deat	h	3. Time of Death	1		
	Physici /Medi		Doris C. Lewi	S						<sup>Month</sup> nuary	6,2007	′ 12:20a №	A		
	Examir	ner	4a. Facility Name (If not institution, give	,		4b. City,	Town, or	Location of	of Death		4c. County of De	ath			
			Sunbridge Care 5. Social Security Number 6. Se		Manage to a heart of		1kt		Od Han Tara		Cec				
	Funeral Director		-	M 2. TKF 7. Age	78 Yrs.	Months	Days	If Under: Hours	Min. Ma	ate of Birth Month, Day	8,1928	irthplace (State or Foreig Country)	n		
			Usual Residence of Decedent						nia.	LCII I	0,1920	PA	_		
	nylan thow	_	10a. State 10b. County		10c. City, Town or i	ocation						10d. Inside City Limits	;		
	Ba-f s	cto	MD Ceci	1	E1kte	on						1 ☐ Yes 24 ☐ No	)		
	vith th	Director	10e. Street and Number		_	10f. Zip				10	g. Citizen of What (	Country?			
	s 23e	eral	370 West Lewis				192				U.S.				
	ter de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces? 1 Yes 2X1	o 13	If Yes, spec	lent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Specify ) n, Puerto Rican	Yes or No- n, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.			
036	urs al	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes	No No	Specify:			Specify: W	nite			
9	be filed within 72 hours after death with the Maryland that Hygiene. Indicate then "natural", or items 23e or 28e-f show event, the Medical Examer must be multiful at	Completed	15. Decedent's Edi (Specify only highest grad	ication	16a. Dec	edent's Usua	I Occupa	ation		1	6b. Kind of Busines	s/Industry			
2	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5	life	e kind of wor DO NOT us	e retired	) )	t or working	i					
12	e filed within Il Hygiene. other then vent, the Me		12		I	lomem			Household						
ano	I be fi	Be	17. Father's Name (First, Middle, Last)						ther's Name ( <i>First, Middle, Maid</i> en <i>Sumame)</i> th Addis						
Maryland 21215-0036	2 should be and Mental Is marked of reumatic ev	၉	William Campbe  19a. Informant's Name/Relationship (T		10h Mai	ling Address	(Strant o				City or Town, State,	7. 0.11	_		
Z	and 2 s salth an n 27 ls ler treu		Reginald D. Lew									1, MD 2192	. 4		
ē,	- F = E		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Nan	na of	!	Date	2	Oc. Location - City of		. 1		
Ë	Page sent o nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ I  3 4 ☐ Donation 5 ☐ Other (Specify)		Bethe!	. Ceme	eter	" уа Су	anuary 2007	, 10,	hesapeak	ce City,MD	,		
Baltimore,	permit. Pages Department of I Important: If ite eny injury or of		21. Signature of Funeral Service Li-	66		2. Name an	d Addres	s of Facility	v			ie croj/n			
<u> </u>	8258		1			259 E	. Ma	in S	é Fune St., E	12+01	n MD 2	21921			
			23a. Part1. Enter the disease, or comp shock, or heart ailure. List only o	icarons that caused ne cause on each lin	the death. Do not er	nter the mode	of dying	, such as	cardiac or resp	piratory arre	st,	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	mete	astatio	Co	100	Ca	ncer	,		Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):								_		
		_	Sequentially list conditions,	Due to (or as a	consequence of):	19									
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 (0) 43 0	consequence or,	J									
Ć.	execu n and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a	consequence of):							-	-		
8760,	icate be executed physician and s the burial-transit	dical	(	i											
9	ng ph as th	Aedi	IS SEMANT.	_								my au	J		
Вох	the death certific y the attending p tched for use as	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome o		□Ectopic pre	onancy				23d. Date of de	,			
о. В	the at	sici	in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	4□Pregnant at t 9□Unknown		Other (spe					Month	Day Year			
<u>α</u>	that the de ad by the detached	Phy	Part II. Other significant conditions co	atributing to death bu	not reculting in the	underh in a co		n in Don't		3a Did taha	loop use sentilibute t	to the cause of death?			
Records,	se og	d by	Anomica	mouning to doubt bu	thot rosalling in the t	andenying ca	iuse givei	mm rann.			2 No 3 P	`			
Sor	w requir been si should I	Completed							_						
Re	he lav e has	dmo							2	4a. Was an autopsy perform	prior to	utopsy findings available completion of cause of			
Vital	icien: Th	e Cc	25. Was case referred to medical					00 81			2 1 □ Yes				
	ysicie s cert direct	O B	examiner?	fospital: 1 ☐ Inpatien	t 2 ER/Outpatie	nt 3 □ DO/	Other		of Death (Che		ce 6 ☐Other (Spe	if i			
0	ding Phys h. After this funeral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time o		c. Injury Work				injury occurred	city)	-		
Ö	ttendin death. stor: Af / the fur	atlc	2 Accident 5 Pending investigation	(World, Day	, oar, mijury	М		es 2□N	No						
Division of	I or Atteno after death Director: I in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	y - At home, farm, st (Specify)	reet, factory,	office		28f. Lo	cation (Stre	et and Number or R State)	ural Route Number,			
	ospitel o hours af unerel D ily filled in		<u> </u>												
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  Certifying Physical Exemi	sicien: To the best of ner: On the basis of a	examination and/or in	th occurred a vestigation,	it the time in my opi	e, date and nion, death	d place, and du h occurred at t	e to the cau	ise(s) and manner a e and place, and du	s stated. e to the cause(s)			
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner stat	9G.		License				d. Date signed (Mon				
1	⊢ ≯ ⊢ ŏ		) In A	10			01	206	370	6	18/07	, Suy, (Gal)			
			30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type	Print)			- / -		1-10-1		_		
2	0		Vistori A	homi.	118 N	orte	87	reet	1 87e	373	Elkton	mo 2/92	1		
	Sta	-	31. Date filed (Month, Day, Year) 9		's Signature	South.	,	V					4		
	Registr	ar	OUII 7	UUI NOON	we so h	1	-								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1177 116 119

			1 - For State Ragistrar	State of Ivia	irylanu /		tificate of L			ene UU / g. No.	01007	
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of Death		3. Time of Death	
	/Medic		MARY K. MA			1			JANUARY	8, 2007	622 PM	
	Examin	er	4a. Facility Name (If not institution, give 18418 BREATHEDSV	·			4b. City, Town, or	BOONSBOR	O	4c. County of Death WASHINGTON		
	Funeral Director		210-30-1703	9X 7. Age □ M 2 💢 F	e (In yrs. last t 64	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, FEB. 8,	Year) 9. Birth Cou 1942 N	place (State or Foreign ntry) IARYLAND	
	and	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits	
	Mary a-f she		MARYLAND WASH	INGTON			ВС	OONSBORO			1 ☐ Yes 2X No	
	or 28	Directo	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Cou	ntry?	
	eath w		18418 BREATHEDSV					21713		U.S		
036	be filad within 72 hours after death with the Maryland tal Hygiena. Id other than "natural", or Itams 23a or 28a-f show event, The Mcdred Examinar must be mailfied at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:		1	Vas Decedent of His i Yes, specify Cubar □ Yes 2\\\ No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specity:		
215-0036	72 ho natur	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16	a. Deced	lent's Usual Occupa	ition Juring most of worki	ina 1	6b. Kind of Business/In		
212	within ena. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. L	HOMEMAKER			OWN HOME		
מ	e filad I Hygi other /ent, I	Be Co	17. Father's Name (First, Middle, Last)				HOURT	18. Mother's Name	(First, Middle, Ma		HOPE	
<u>Nar</u>		To B	HERMAN ELWOOD VA	LENTINE, S	SR.			KATHERI	NE EDNA	BROWN		
, Maryland	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marks any injury or other traumatic once.	ſ.	19a. Informant's Name/Relationship (7 RONALD MAY, HUSB.		1	8418	BREATHEI			City or Town, State, Zip NSBORO, MD	21713	
Baltimore,											own, State , MARYLAND	
Balt	permit. Departr Importa		21. Signature of Funeral Service Licent	2	1	22 BA	Name and Addres ST FUNERA	AL HOME		NATIONAL P , MARYLAND	IKE 21713	
			23a. Part1. En er the disease, or comp shock, or heart failure. List only	lieations that caused one cause on each line	the death. Do	not ente	er the mode of dying				Approximate Interval Between	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	1010.		Concer				Onset and Death  3 munt	
	Examiner			Due to (or as a	consequence	e of):			•			
-	lad nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence	∋ of):						
8/60,	sate be execut <b>ad</b> hysician and the burial-transit		that initiated events resulting in death) Last	c. Due to (or as a	ı consequence	e of):						
289	rtificate ng physi as the l	edica	d.									
O. BOX	death ce e attendii d for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year	
7	law requires that the de as been signed by the 2 should be detached	by Ph	Part II. Other significant conditions co	ntributing to death bu	t not resulting	in the un	derlying cause give	n in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?	
ecords,	en sig	ed b							1 ☐ Yes	2 ☑No 3 ☐ Prob	ably 4 Unknown	
r	The lay	Completed							24a. Was an autopsy performe	d? death?	psy findings available inpletion of cause of	
Vitai	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	12-1				26. Place of Death	(Check only one)			
TO UC	To the Hospital or Attending Physician: within 24 hours after deals, as the Funatal Director: After this certified completely filled in by the funeral director, to	ion: To	27. Manner of Death 1 Natural 5 Pending	Hospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day		Outpatient Time of Injury	28c. Injury Work	at 2	ne 5 ሺ Resident 28d. Describe how	ce 6	/)	
DIVISION	or Atten after deall Director: in by the	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, f (Specify)	arm, stre	M 1 Tes 2 No			(Street and Number or Rural Route Number, Fown, State)		
	Hospital 24 hours Funaral stely filled	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Examone)	sician: To the best of ner: On the basis of and manner stat	examination a	ge, death nd/or inv	occurred at the time	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manner as si and place, and due to	ated. the cause(s)	
	To the within To the comple	Med	29b. Signature and title of certifier	maining stat			29c. License	number	29d	. Date signed (Month,	Day, Year)	
			Drichael J.	Nelsom	MI	0	04	11667		1.9.07		
4			30. Name and address of person who co	. /1 .:								
†ر	1-60 Sta	0	31. Date filed (Month, Day, Year)	32. Registrar		111	10 /he	dical C	ames	Maje-7 K	ma 12.	
	Sta Registra		IAN 10 20	107	A	1	1. 10 1					

			for Amend Item 20			artment	t of H e of L	ealth a Death	and Me		giene) Reg. No.	007	01610	
		1-	Decedent's Name (First, Middle, Last						2	2. Date of Dea	ath Day	Year	3. Time of Death	
	Physici		Harry Scott M	vers						Month 01	07	2007	4:09 a <sup>M</sup>	
Sales and	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death					4c. C	ounty of Dear		
		. 4	NMS Health Care	9		На	ger	stow	n		Wa	ashin	gton	
NE.	Funeral		5. Social Security Number 6. S		ge (In yrs. last birthday	) If Under Months	1 Year Days	If Under	24 Hrs. 8 Min.	B. Date of Birt (Month, Da	th y, Year)	9. Bir	thplace (State or Foreign ountry)	
-	Director		232-34-4133	ДМ 2□F	69 Yrs.				0	1-29-	-1937	PA	1	
	pu s		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinational be notified at once.	ō	WV Berkel	AV	Martins	shura							1 ☐ Yes 2 No	
		Director	10e. Street and Number	. C y	Par CIII.	10f. Zip					10a. Citize	n of What Co	ountry?	
	with	ក់	84 Petersburg	Ln.				254	01			USA		
	eath	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Deced	lent of Hi			ify Yes or No ican, etc.)	- 14	Race - Ame		
	ter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀						ican, etc.)	1	Black, Whit		
336	urs al	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 Yes 2	2 X No	Specify:			S	pecify: [	Mhite	
21215-0036	2 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Decupation (Specify only highest grade completed) (Give kind of work done during most of workin						a	16b. Kind	of Business	/Industry		
218	within 7 ene. than "r	ple	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT us	e retired	)						
	or th	Son	8		Co	onstr	uct:						ruction	
nd	d oth	Be	17. Father's Name (First, Middle, Last)							(First, Middle,				
yla	Meni Meni arke	Jo	James H. Myers							Belle				
Maryland	12 should be filled within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mes		19a. Informant's Name/Relationship (T Lucille Nisewar	ype, Print) ner/sist		-	•			Route Numbe	-		Zip Code)	
	1 and Health em 27		20a. Method of Disposition	in-l	aW 20b. Place of Disp			- • /	Da			tion - City or	Town State	
ore	Pages 1 nent of H int: If ite		1 🔀 Buriat 2 □ Cremation 3 □		cemetery, cre	ematory or o	ther place		1/10/	2007				
ţi.	permit. Pag Department Important: I eny Injury o		4 □Donation 5 □Other (Specify		Roseda				-W	<del>V-</del> sedale	Mari	tinsb	urg, WV	
Baltimore,	permit. Departr Imports eny inj		21. Signature of Funeral Service Licen	HAR	r 2	917 C	emet	tery	Rd.			петат	поше	
	tin z e d		23a. Pant1. Enter the disease, or com	dications that cause		Marti				25404			Approximate	
			shock, or heart failure. List only	one cause on each	ine.				521012001		,,		Interval Between Doset and Death	
j.	Physician		disease or condition resulting in death)	a	DS42JC	(0	INC	ly					37	
	/Medical Examiner			Due to (or as	a consequence of):								34	
15		ā	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):								37	
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c											
	al-tra	xai	resulting in death) Last	Due to (or as	a consequence of):									
8760,	cate be executed by sician and the burial-transit	cal	(	d										
.89	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		3											
Вох	leath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pr					23	d. Date of de	*	
	death e atte d for	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant a		Other (sp						Month	Day Year	
P.0	that the de ned by the a detached f	hys	9 Unknown	9□ Unknown										
	res tha igned be det	by P	Part II. Other significant conditions of	ontributing to death t	but not resulting in the	underlying c	ause give	en in Part I		23e. Did t	obacco use		o the cause of death?	
Records,	w require been sig should b									10'	Yes 2 🗆	No 3□P	robably 4 Unknown	
S	aw re	plet								24a. Was		24b. Were a	utopsy findings available completion of cause of	
m	sician: The law certificate has l irector, page 2 s	Completed								perfo	rmed?	death?		
Vital		Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	one)			
<b>1</b>	Physician: this certific ral director,	To	1 Yes 25 No	Hospital: 1 Inpati	ent 2 EP/Dutpatio			4 4	ursing Hom	e 5 🗆 Resi	dence 6	□Dther (Spe	ocify)	
n of	ding Pt h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Time ay Year) Injury		8c. Injury Work			Bd. Describe I	how injury	occurred		
<u>o</u>	Attending r death. ector: After by the fune	Sati	2 Accident investigation			М		Yes 2						
Division	r Att ter d irect n by t	Certification:	3 Suicide 6 Could not be determined	286. Place of in	ijury - At home, farm, s itc. <i>(Specify)</i>	treet, factory	, office		28	Bf. Location (: City or To		Number or R	ural Route Number,	
	urs al	ပိ												
	Hosp 14 hol Fune Fune	lica	29a. Certifier 1-62 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best niner: On the basis of and manner si	t of my knowledge, dea of examination and/or i	investigation	, in my o	ne, date ar pinion, dea	nd place, ar ath occurre	d at the time,	date and p	na manner a lace, and du	s stated. e to the cause(s)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29b. Signature and title of certifier	and manner s	iu.ou.	290	c. License	e number			29d. Date	signed (Mon	th, Day, Year)	
	5 <u>4 K</u> 3			35			D	523	77		0/	7 4	200	
			30. Name and address of person who	completed assess of	death (Item 22a) /Tues	Print)		ر کے د	2)		-/ -	7-9	-	
0	54-2				Ct., Hage		wn -	MD	2174	40				
	St.	ate	Dr. Waseem, 11. 31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	/ /	,							
	Regist		JAN 10 2	007	rar's Signature	poste								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Wilson Seebert McCullough JANUARY 8. 2007 4:20A.M<sup>™</sup>. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeder's Nursing Home Washington County

9. Birthplace (State or Foreign Country)

Country) Boonsboro
If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Months 1 M 2 □ F Yrs. Director 231-16-2260 Dec 20 1923 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show notified at 1 Yes 2 No Directo Maryland Washington Boonsboro or 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be MÉ: MC ピルレルイボ,  $W_{(LS)}$ N Baltimore, Maryland 21215-0036 141 S. Main 21713 Funeral U.S.A. 12. Was Decedent Ever in U.S. 1
Armed Forces?
1 전 Yes 2 □ No 1-19-43
If Yes, Give
Year or Dates: 1-24-46 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced 1-24-46 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Sandblasting Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Howard McCullough Beulah Shaw 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3 Department of Health as Important: If Item 27 is any injury or other trau Mary A. Roof (daughter) 11421 Locustdale Terrace Germantown Maryland 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 1-11-2007 Hagerstown Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Douglas A. Fiery Funeral Home 23a. Part. Enter thy disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. <u> 1331 Eastern Blvd. N. Hagerstown Maryland 21742</u> Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Partion-/Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin be executed burial-transi and Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a detached f o 9☐Unknown 9 ☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐ Yes or Vital 1□ Yes 2 40 25. Was case referred to medical examiner? Be 26. Place of Death | Check onl one Hospital: 1 ☐ Inpatient Other: 4 Harsing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t al or Attending F after death. I Director: After d in by the funera Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DU MO D18319 JA~ 8, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 03H-4+1 340 MILL STREET, HAGERSTOWN, MARYLAND 21740 301-739-7100 DR. VASANT DATTA 31. Date filed (Month, Day, Year). 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Benjamin	В.	Merryman	
Benjamin	В.	Merryman	

benjamin b. ivie		1- For State Registrar Certificate of Death	, 5	Reg No 2007 01612						
Physici Medical Exami			2. Date of De Month January							
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dorchester General Hospital  Cambridge		4c. County of Death  Dorchester						
Funeral Director		5 Social Security Number 6, Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 214-34-2782 1		irth(MM/DD/YYYY) 9. Birthplace (State or 1 12, 1937 reign Country Maryland						
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits						
Maryland  28a-f show d at once.	for	Maryland Dorchester Cambridge  10e Street and Number 10f Zip Code		1 Yes 2 No						
r death with the Maryland or items 23a or 28a-f sho must be notified at once,	I Director			10g Citizen of What Country? USA						
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important of Fleath and Mental Hygiene Important. If tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	by Funeral	1 Yes 2 No specify:		o- 14. Race - American Indian, Black, White, etc  Specify: White						
72 hours	eted t	15 Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a Decedent's Usual Occupation (Give Industry)  during most of working life. DO NOT	kind of work done use retired)	16b. Kind of Business/Industry						
.0036 within? within? giene giene her than	Completed	Truck Driver  7 Father's Name (First, Middle, Last)	's Name (First, Middle,	Transportation						
1215- d be filed ental Hy arked of	Be	George Carroll Merryman Eth	hel Edith .	Jones						
MD 2 12 should th and M 127 is m unatic e	٢	19a. Informant's Name/Relationship (Type, Print)  Joyce Ann Smith Merryman/Wife 19b. Mailing Address (Street and Num 5921 Ross Neck Ro	nber or Rural Route Nu d., Cambric	imber, City or Town, State, Zip Code) dge, MD 21613						
ges I and tof Heal		20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State						
caltim rmit Pa spartmen sportant jury or or		4 Donation 5 Other Specify.  21 Signature of Funeral Service Licensee  22 Name and Address of Facility  Curran—Bromyo								
Physician	4	21 Signature of Funeral Service Licensee  22 Name and Address of Facility Curran—Bromwe 308 High St.,  23a. Part I. Enter the disease, or com Irications that caused the death. Do not enter the mode of dying, such as ca	Cambridge ardiac or respiratory ar	, MD 21613 rrest, shock, or heart Approximate Interval						
/Medical xaminer		failure. List only one cause on each line. Lymphocytic myocarditis  Immediate Cause (Final disease or condition resulting in death)  The failure is the condition of the condition of the condition of the condition resulting in death)  The failure is the condition of the conditio	lar disease	Between Onset and Death						
1	<u>.</u>	Sequentially list conditions.								
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
xecuted	al Ex	M UNPENDED X AMENDED #23a,PII, per ME, g865, 3/17/07 T.	r -							
760, cate be e physicial	-	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery							
Box 68760, re death certificate be executed the attending physician and red for use as the burial - transit	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify)	pregnancy	Month Day Year						
D.O. Both the described by the adetached for			irt I 23e. Did t	obacco use contribute to the cause of death?						
ds, P.	ted by	Diabetes Mellitus	1 Ye	es 2 No 3 Probably 4 V Unknown  an 24b Were autopsy findings available						
Division of Vital Records, P.O. In the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this centificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed	Hypertensive atherosclerotic cardiovascular disease	auto	psy prior to completion of cause of death?						
Vital R ysician: 1 his certific	Be	25. Was case referred to medical examiner? Hospital: 4 Propinal: 4	4.5							
ing Phy: After thi	n: To	27 Mapper of Dooth	? 28d. Describe	Residence 6 Other.  how injury occurred						
Divisior spiral or Attencours after death reral Director: filled in by the	Certification:	5 Pending Investigation 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.		Street and Number or Rural Route Number, City						
Divospital of hours af hours af uneral Divospital of hours af uneral Divospital of hours af the divospital of hours after a hours a			or Town,							
Division To the Hospital or Attentivitin 24 hours after death To the Funeral Director:	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and plate one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		and place, and due to the cause(s)						
	Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d Date signed (Month, Day, Year)  January 4, 2007						
		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica Pollak MD Assistant Medical Everpiner 111 Ponn Street Rel	Itimore MD 2422							
St	ate	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Balle 31. Date filed (Month, Day Year) 8 2007		01						
Regist	rar	THE WOLUM DISTURD TO SPENCE								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 4, 2007 **Physician** 1:25 AMM JESSIE LEE MAYHEW /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Southern Maryland Hospital Clinton If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye) 06-25-17 If Under 1 Year 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** South Carolina Months Days Hours Min. 1 □ M 2 🛣 F 89 Director 579-26-9684 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo Clinton Maryland Prince Georges filed within 72 hours after death with the I Hygiene. ither than "natural", or Items 23a or 28a-10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20735 6509 Woodley Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖺 No Baltimore, Maryland 21215-0036 <u>ک</u> **Black** Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NIH - Federal Gov't Housekeeping Aide Department of Health and Mental Hygic Important: If Item 27 Is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Wright Preston Anthony 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20735 6509 Woodley Road, Clinton, MD Cecilia Wright 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem; 01-12-07 Suitland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Strickland Funeral Services, P.A 21. Signature of Funeral Service Ligens 20748 6500 Allentown Road, Camp Springs, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner BACTERIA IN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine DECUBITAL ULCER certificate be executed and use as the burial-trai Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 ALZHEIMERS Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ BREASI 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 10 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No spital or Attendi lours after death. neral Director: A death. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

State Registrar

Anderson 31. Date filed (Month, Day, Year) JAN 1 0 2007

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

9400

29c. License number

Livings/m Rd #350 FT. ass/HINGON

29d. Date signed (Month, Day, Year)

			For State Registrar	State of I	Maryland	•	artmen tificate			nd Me		gien Reg. N	$2 \cap \mathbb{R}$	7	01614
	Director!		1. Decedent's Name (First, Middle, L	ast)						2.	Date of De Month	aath Da	ay .	Year	3. Time of Death
	Physici /Medic		James Edward								_01_	0		0.7	7:23A M
F	Examin	er	4a. Facility Name (If not institution, go				4b. City,	Town, or l	Location of	Death			. County o		
			Prince George			a an factoria and a	Che If Under	ever	1 y If Under 2	4 Hrs 0	Date of Bir				eorge
	Funeral		5. Social Security Number 6. $247 - 58 - 9133$	Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. I	67 <sup>Yrs.</sup>	Months	Days	Hours	Min.	(Month, Da	ay, Year	)	Coun	ace (State or Foreign try) ington,
	Director		Usual Residence of Decedent			0 /					2/03,	/19	39	Darı	ington,
	wo.		10a. State 10b. County		10c. City	, Town or Lo	cation				-			10	Od. Inside City Limits
	Mar	ţō	MD Prince	e George	Lan	idovei	c								1∏Yes 2□No
	h the	Director	10e. Street and Number				10f. Zip Code					10g. C	itizen of W	hat Coun	try?
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	ems erms	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.:	S. 13.	Was Deced	lent of His	panic Origi , Mexican,	in? (Specif Puerto Ric	y Yes or No an, etc.)	0-	14. Race Black	- America , White, e	
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75	n 72	lete	(Specify only highest g	rade completed)		(Give	kind of wor	rk done du se retired)	ring most			100.1	and or but	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	a stry
12	I within 72 hours after death with the Maryler liene. The Madical Examinet must be notified at the Madical Examinet must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	Dire	ctor	Of	Trai	lning	3		NOBI	ĿΕ	
b	E T E	BeC	17. Father's Name (First, Middle, Las						18. Mother	's Name (F	irst, Middle	, Maide	n Sumame	)	
<u>la</u> r		To B	James Edward N	civer S	r.				Hele	en G	rahan	n			
Maryland 21215-0036	s 1 and 2 should t Health and Mer ttem 27 ie marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street ar	nd Number	or Rural F	Route Numb	er, City	or Town, S	State, Zip	<sup>Code)</sup> 20785
Σ,	and and in 27		James E. McIve	er III/	Son	1914	Dut	ch_V	Vi1,1a	age ]	<u>Orive</u>	La	andox	zer.	Md.
ore	of Hee		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3	☐Removal from Sta	20b. P	lace of Dispo emetery, crer verda	natory or o	ne of ther place	)	Date			ocation - (		
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Baltimore,	permit. Pages Depertment of h important: if its eny injury or of		21. Signature of Funeral Service Lic	ensee		22	2. Name an	d Address	s of Facility	lurra	ay Fu	iner	al F	lome	- 4804
	40 = • a		Phillip!	Sell 18							Was		gtor	D, D	C 20011 Approximate
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	/Medical Examiner		1	·	as a consequ										
В		ē	Sequentially list conditions, if any leading to immediate		ic St		. S								
	nted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
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8760,	cate be executed obysicien and the burial-transit														
Ö	tificat ng phy as th	Physician/Medical										— т			
Вох	eath certific attanding p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth	me of pregna		∃Ectopic pr	egnancy					23d. Date		
	o deal	sich	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnan 9☐Unknow	t at time of de		Other (sp						Mon	UI V	Day Year
P.0	thet the de ed by the detached	Phy	9 Unknown			ulaine in about			n in Don't		220 Did	tobacco	uco conto	buto to th	e cause of death?
	8	b	Part II. Other significant conditions			ulting in the u	ndenying c	ause give	nın Parti.		_			3 ☐ Prob	
Records,	A require been si should	Completed	End Stage Ren	al ralli	ire						-				
ec Sec	e law has t	npl	-								24a. Was		pi	ere autor rior to cor eath?	osy findings available inpletion of cause of
a F											1 Yes	2 <b>X</b> N			2 <b>X</b> No
Vital	Physician: this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	and the control of th	TD(0		Othe	c		Check only		a (10th)		
of		. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inp	njury	ER/Outpatier 28b. Time o		28c. Injury Work	4 🗀 NUI		5 Res				"
0	nding f th. : Aftar s funer	ig.	1 Natural 5 Pending 2 Accident investigat		Day Year)	Injury	м		? ′es 2 ∐ N	lo					
Division	Attending r death. ector: Attai	E C	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of			reet, factory	y, office		28	Location City or To			r or Rura	l Route Number,
á	s afte	Certification:	4 [] Homicide	Building	, etc. (Specify	γ)					City of 10	WII, SIA	16)		
	To the Hospital or Attendi Within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (		Physician: To the be aminer: On the basi and manner	s of examina										
	within 2 To the	Me	29b. Signature and title of certifier	7	17		290	c. License	number			29d. D	ate signed	(Month,	Day, Year)
	(14)		1 Did	(a) Dig	gh			D	456	60			1/3/	c 3	
,	Cate		30. Name and address of person wh	o completed cause	of death (Item	n 23a) (Type,	Print)						-		
	DE		ppinder Singh	14300	Galla	ng Fo	x La	ne_#	124	1 Bov	ie,	Md.	207	15	
		ate	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	iture									
	Regist	rair	JAN 1 0 2007	Them 10	. Dol	MI									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** F. NSEME MANA ODETTE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months 1 ☐ M 2 🖸 F 54 JAN 1 1953 CAMEROON NONE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County YAOUNDE 1X Yes 2 □ No Cameroon Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code CAMEROON NONE NONE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: AFRICAN þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 4 YRS TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSINE EKEDI FOUMANE MANA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11320 BROKEN BOW COURT BELTSVILLE, MD 20705 ANTHONY FONEBI/FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) FAMILY PLOT Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State YAOUNDE, CAMERON 1/15/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ) week disease or condition resulting in death) Due to (or a a consequence of): ncontrelle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner eves Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 1 🗌 Yes 3 Probably 4 Unknown mus 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2X No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed use as the burial-trans Division or Vital Records, P.O. Box 68760, attending physician signed by the or Attending Physician: funeral After ours after death.

neral Director: A
filled in by the fu within 24 hours a

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

"natural"

the Medical other than

Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, in once.

**Physician** 

/Medical

Examiner

death with the Maryland

1 and 2 should be filed within 72 hours after Health and Mental Hygiene.

21215-0036

Baltimore, Maryland

Physician/Medical Completed by Be Certification: To

Medical

6 Could not be determined

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year,

30 flame and address of person who completed cause of death (Item 23a) (Type, Print) 1200 6304 Med

31. Date filed (Month, Day, Year) State

(Check only

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 4:30 PM JANUARY 6, 2007 MARGARET LILLIAN MYERS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🖾 F **Yrs** 206-24-9520 JULY 29, 1933 PENNSYLVANIA 73 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🖔 No Director MARYLAND MONTGOMERY STLVER SPRING 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 U.S.A. 14016 CRICKET LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates 1 Never Married 2 Married 2 X No 1∐ Yes 2∐X No Specify. þ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 DOMESTIC ENGINEER DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET MOLNAR JOHN McNALLY 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14016 CRICKET LANE, SILVER SPRING, MARYLAND 20904 DONALD L. MYERS - SPOUSE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) JANUAR Ate 25 20a. Method of Disposition Department of H Important: If Ite any Injury or of once. 1 🖫 Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final HOURS MYOCARDIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of) CORONARY ARTERY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ner YEARS DIABETES MELLITUS TYPE 2 that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☒ No 5 Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

**Funeral** 

Director

or 28a-f show a notified at

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is marked

27 item.

Health

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-transit ours after death.

neral Director: A
filled in by the for within 24 hours a

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

dical Exami	Cause (Disease or injury that initiated events resulting in death) Last
ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
ertification: To Be Completed by Physician/Medical Exami	Part II. Other significant condition
o Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
ertification: 1	27. Manner of Death  1 🖾 Natural 5 ☐ Pendin 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ

Medical

31. Date

23e.	Did tobacc	o us	se conti	ribute to the ca	use of	death?
	1 ☐ Yes	2 🛚	] No	3 ☐ Probably	4 [	]Unknow
2 <b>4</b> a.	Was an autopsy	?	24b. \	Were autopsy forior to comple	inding tion of	s availab cause of

1 ☐ Yes 2 ☐ No

25. 1140 040		to modioai	1			
examine 1 ☐ Yes	r? 2 <b>⊠</b> No		Но	spital:	1 X Inpatient	2[
27. Manner o 1 X Natu 2	ral 5 dent	☐ Pending investigation	- 1	28a.	Date of Injury (Month, Day Yo	ear)
3 ☐ Suid	il de	Could not be determined		28e.	Place of injury	- At

08

: 1 📉 Inpatient 2 🗆	ER/Outpatient	3□ D	OA Other: 4	☐ Nursing H	lome 5	Residence	6 □Other (Specify)
Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 □No	28d. De	escribe how inju	ry occurred
Place of injury - At he building, etc. (Specif	ome, farm, stree	t, facto	ry, office			cation (Street ar	nd Number or Rural Route Number, e)

D36046

26. Place of Death (Check only one)

29a. Certifier (Check only one)	1 \(\) Certifying Physician: To the best of my knowledge 2 \(\) Medical Examiner: On the basis of examination a and panner stated.	
29b. Signature an	d tile of certifier	

		due to the cause(s) and manner as stated. It the time, date and place, and due to the cause(s
L	29c, License number	29d. Date signed (Month, Day, Year)

1□ Yes

			1	_//		-
291	o. Signature	and title of cert	ifier	1/2	1	-
	1	de		VC	- S/A	-
20	Namo and	address of pers	n who com	oleted cause of	death (Item 23)	a) (Type

JANUARY 7, 2007

2⊠No

MERENDINO 10215 FERNWOOD ROAD. SUITE 405, BETHESDA, MARYLAND 20817 JOHN J. JR. M.D., filed (Month, Day, Year)

State Registrar

10

Physician /Medical Examiner  NATIONAL NAVAL MEDICAL CENTER  Funeral Director  1. Decedent's Name (First, Middle, Last)  MICHAEL ANGELO MECCA  2. Date of Dea Month JAN  4b. City, Town, or Location of Death  BETHESDA  NATIONAL NAVAL MEDICAL CENTER  5. Social Security Number 187-05-6144  12 M 2 F 87  Nonth Days Hours Min.	Day   Year   3   2007   9:26 A   M
MICHAEL ANGELO MECCA   JAN	3 2007 9:26 A M  4c. County of Death  MONTGOMERY  9. Birthplace (State or Foreign County) Pennsylvania  10d. Inside City Limits 1 Yes 2 No  Og. Citizen of What Country?
NATIONAL NAVAL MEDICAL CENTER  BETHESDA  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 187-05-6144 18 M 2 F	MONTGOMERY  9. Birthplace (State or Foreign Country)  Pennsylvania  10d. Inside City Limits  1 □ Yes 2 ▼No  Og. Citizen of What Country?
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Months Days Hours Min.	9. Birthplace (State or Foreign Country) 1919 Pennsylvania  10d. Inside City Limits 1 Yes 2 No  Og. Citizen of What Country?
187-05-61/4 1XM 2DF Months Days Hours Min. (Month, Day	1919   Pennsylvania   10d. Inside City Limits   1 □ Yes 2 录No   10g. Citizen of What Country?
Director Dec. 22	10d. Inside City Limits 1 ☐ Yes 2 ☑No 0g. Citizen of What Country?
Usual Residence of Decedent	1 ☐ Yes 2 承No
Maryland Montgomery Rockville	0g. Citizen of What Country?
Maryland Montgomery Rockville  Maryland Montgomery Rockville	
7200 Panorama Drive 20855	
7200 Panorama Drive  20855  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1944— 11. Never Married  12. Was Decedent Ever in U.S. Armed Forces? 1944— 12. Was Decedent of Hispanic Origin? (Specify Yes or No-Hyes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian,
S 3 Widowed 4 Divorced Year or Dates: 1966 1 Yes 2 ₩ No Specify:	Black, White, etc.  Specify:  White
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  16b. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  16c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  16c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  16c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)	16b. Kind of Business/Industry United States
College (1-4or 5+)  Elementary/Secondary (0-12)  College (1-4or 5+)  Officer	Air Force
To provide the state of the sta	
Peter Mecca  Peter Mecca  19a. Informant's Name/Relationship (Type, Print) Cecile S. Mecca/ Spouse  20a. Method of Disposition  Peter Mecca  19b. Mailing Address (Street and Number or Rural Route Nu	
Cecile S. Mecca/ Spouse 7200 Panorama Drive, Rockville	, Maryland 20855
Cecile S. Mecca/ Spouse  7200 Panorama Drive, Rockville  20a. Method of Disposition  1 Burial 2 © Cremation 3 Removal from State  4 Donation 5 Other (Speak)  21. Signature of Funeral Service Litenses  22b. Place of Disposition (Name of cematory crematory of other place)  Metropolitan  Crematory  22. Name and Address of Facility DeVol Fune  Deer Park Drive, Gaitherst	20c. Location - City or Town, State
4 Donation 5 Other (Society)  Crematory  2007  A	lexandria, Virginia
21. Signature of Funeral Service Libense Deer Park Drive, Gaithersh	
23a. Rant. Therefine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr	est. Approximate
Spock/ly (heart splitter. List only one cause on each line.  Immediate Cause (Final disease or condition CARDIOGENIC SHOCK	Interval Between Onset and Death
/Medical resulting in death)  a. ORRESTORED SHOCK  Due to (or as a consequence of):	
Examiner Sequentially list conditions, b. RENAL FAILURE	
The state of the s	
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
Cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  C. Due to (or as a consequence of):  23c. If yes, outcome of pregnancy 1	
A as the state of	
To see the past 12 months?  If FEMALE:  23c. If yes, outcome of pregnancy  1   Live birth 2   Fetal death 3   Ectopic pregnancy  1   Live birth 2   Fetal death 5   Other (specify)	23d. Date of delivery
	Month Day Year
	pacco use contribute to the cause of death?
(a) So	s 2X No 3 Probably 4 Unknown
	n 24b. Were autopsy findings available
The Page of Page 1   Page of Page	y prior to completion of cause of
To be a considered to medical axaminer?  25. Was case referred to medical axaminer?  1   Yes   25. Was case referred to medical axaminer?  1   Yes   25. Was case referred to medical axaminer?	X
1 Ves 2 VNo 1 Inpatient 2 ER/Outpatient 3 DOA Outer 4 Nursing Home 5 Reside	
27. Manner of Death  28a. Date of Injury  28b. Time of Injury at Work?  28d. Describe no Injury	w injury occurred
25. Was case referred to medical examiner?  1	reet and Number or Rural Route Number,
27. Manner of Death 1 Natural 2 No Describe ho 2 No Descr	, State)
29a. Certifier  1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the care of the control of the care of the control of the care of the ca	tuse(s) and manner as stated. ate and place, and due to the cause(s)
and manner stated.  29b. Signature and title of certifier  29c. License number	9d. Date signed (Month, Day, Year)
	W 04 2007
70	AL MEDICAL CENTER
ERICH F, WEDAM LCDR MC USN BETHESDA MD	
State Registrar  31. Date filed (Month, Day, Year)  JAN 0 5 2007  32. Gegistrar's Signature	

State

Assistant Medical Examiner

00 30. Name and address of person who completed cause of death (Item 23a)

200

Tasha Greenberg MD.

31. Date filed (Month, Day Year)

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 9, 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3:11 P M **Physician** Martin Wright Mayer January 2, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Arnold Future Care Chesapeake 8. Date of Birth (Month, Day, Year)
Dec. 17, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Yrs. 220-05-7351 87 1919 New York Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Arnold Maryland Anne Arundel 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21012 U.S.A. 510 Andrew Hill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1⊠Yes 2□No If Yes, Give Year or Dates: 1941–45 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed if Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) be filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Insurance District Supervisor 18. Mother's Name (First, Middle, Maiden Surname) and Mental Hv. 7 is mark 17, Father's Name (First, Middle, Last) Be Ruth Ellis Eugene S. Mayer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 Locust Avenue Annapolis, Maryland Michael W. Mayer/son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Department of Important: If It any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 □ Removal from State 1/4/2007 Baltimore Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun III Service Liceys 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced Dementia **Physician** 6 vears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) s been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy perform 2**XX**Io certificate 1□ Yes Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 □Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

Box 68760. P.O. Division or Vital Records,

Certification: after death the in by 1

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only

10

ō Hospital

the

within 24 hours a Medical completely one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 2, 2007 D46360

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8601 Veterans Highway Millersville, Maryland Michael A. Ankrom, MD

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, State Registrar

			1 _ State	ate of Ma	ryland / [	•	rtment of F tificate of t				iene g. No. 🤈 🗍	O 77	01620
	*1 = 1 ×		Registrar  1. Decedent's Name (First, Middle, Last)						2.	Date of Deat	h I	U /	3. Time of Death
1	Physicia	_	Charles Alfred Mei	zner						Month anuary	2, 200	Year 7	10:04 A <sup>M</sup>
100	/Medic Examin		4a. Facility Name (If not institution, give stree				4b. City, Town, o	r Location	of Death		4c. County	of Death	
		4	Spa Creek Center				Annapol				Anne	Arur	
*	Funeral Director		5. Social Security Number 6. Sex 1 1 1 M		(In yrs. last bii	rthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. 8.	Date of Birth (Month, Day, 11/15/	<sup>Year)</sup> 1930	9. Birthp Cour Ohio	lace (State or Foreign try)
	yland how at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation					1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	e Mar 3a-f s tiffied	cto	Maryland Anne Arund	e1		Edg	gewater			T.			
	or 24	Directo	10e. Street and Number				10f. Zip Code	7		10	Og. Citizen of V	SA	itry?
	s 23a	era	3301 Kenney Court	Vas Decedent E	ever in II S	13 1	2103		rigin? (Snecify	Yes or No-		e - Americ	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Walta Olalus	Armed Forces?  XYes 2 N Yes, Give ear or Dates:		10.	Nas Decedent of H If Yes, specify Cuba I□Yes 2☐No			an, etc.)		k, White,	
Maryland 21215-0036	"natura edical E	Completed by	15. Decedent's Educatio (Specify only highest grade con	n mpleted)	16a	. Dece	dent's Usual Occup kind of work done OO NOT use retired	ation during mos	st of working		16b. Kind of Bu	usiness/In	dustry
7	withir iene. than the M	dmo		College (1-4or 5- years		_	cutive				AT&	Т	
9	illed Hyg other	BeC	17. Father's Name (First, Middle, Last)					18. Moth	er's Name (F	irst, Middle, N	Maiden Surnan	ne)	
<u> a</u>	uld be denta rrked rtic ev	ToE	Alfred Meizner					I	Rozella	a Fietz	Z		
<u>a</u>	2 sho and h is ma	•	19a. Informant's Name/Relationship (Type. I				ng Address (Street				-		Code)
≥ ``	and sealth m 27		Mary Jo Meizner/ Wif	e			1 Kenney	Court	t, Edge		, MD 21 20c. Location -		own State
altimore,	Pages 1 ment of H ant: If Ite ury or ot		20a. Method of Disposition  1 ☐ Burial 2 【 Cremation 3 ☐ Remode 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	cemete	ery, cřer as C	natory or other pla Crematory		1-6-07		Edgewat	ter,	MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Sorvice Idensee			29	2. Name and Addre	ons I	Island	Rd. Ed	lgewate		
Γ			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused ause on each lin	the death. Do e.	not ent	er the mode of dyir	ng, such as	s cardiac or re	espiratory arre	est,		Approximate Interval Between
÷	Physician		Immediate Cause (Final disease or conditionaa.	Cor	e hrav	6.5	che or	HV	، ياراد،	2,10			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence	of):							
		e.	Sequentially list conditions, if any leading to immediate	Due to (or as a	a consequence	of):				_		-	
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
ó	ficate be executed physician and is the burlal-transit	Еха	that initiated events c resulting in death) Last	Due to (or as a	a consequence	of):	_						
58760,	te be iysicia ne bu	edical	d										
_	ntifica ng ph s as th		IF FEMALE:		_								
P.O. Box	The law requires that the death certific ate has been signed by the attending p oage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	lf yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 ☐ Fetal deat		Ectopic pregnanc Other <i>(specify)</i>	у				te of delive onth	ery Day Year
	that the by detact	/ Ph	Part II. Other significant conditions contrib	uting to death bu	ut not resulting i	in the u	nderlying cause giv	en in Part	I.	23e. Did tok	acco use cont	tribute to t	he cause of death?
rds	quires n sigr uld be	ed by								1 □ Ye	es 2 <b>□74</b> 0	3 ☐ Prol	pably 4 □Unknown
Division or Vital Records,	The law re te has bee age 2 sho	Completed								24a. Was a autops perforr 1  Yes 2	ned?	Were auto prior to co death? 1 ☐ Yes	ppsy findings available mpletion of cause of
<u>ta</u>	ian: rtifica stor, p	Be C	25. Was case referred to medical					26. Plac	e of Death (C				
<u>_</u>	hysic his ce I direc	To E	examiner? 1 Yes 2 No Hosp	1 🔲 Inpatie	nt 2 ☐ ER/O			4 L1 N			ence 6 DOth		(y)
n o	ing P		1 ☑Natural 5 ☐ Pending	28a. Date of Injui (Month, Day		Time o Injury	Wo	ryat rk? ]Yes 2.[		l. Describe ho	w injury occur	red	
ivisio	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of injubul		arm, str	reet, factory, office	1163 2		Location (St City or Town	reet and Numb n, State)	per or Rur	al Route Number,
	lospital of hours a cuneral Cuneral C		29a. Certifier (Check only)  29a. Certifying Physicia (Check only)  Medical Examiner:										
	thin 24	Medical	29b. Signature and line of certifier	and manner sta	ited.		29c. Licens	se number		2	9d. Date signe	d (Month,	Day, Year)
_	Z × S	_	Menus				(	3)0.	26		1/21	JUV	7
7	121		30. Name and address of person who compl	eted cause of de	eath (Item 23a)	(Type,	Print)	762	(l.,	Len M	20) 2	16	/ §
	3H Sta		31. Date filed (Month, Day, Year)		ar's Signature		hart s	- 0	~~r		v	. 4	
	Regist	ar	. <b>JAN 0 4</b> 200	A STATE OF THE PARTY OF THE PAR	TO JO	14	1000						

			For State	State of Mai		artmer	nt of H			ntal Hyg		007	01621
			Registrar  1. Decedent's Name (First, Middle, Las	1)		rimour			2	. Date of Deat			3. Time of Death
	Physici /Medio	al	Loise Medlin			4h City	Town o	r Location of		Month O 1	Day O.3	Year 2007 ounty of Death	1:10 PM
	Examin	er	4a. Facility Name (If not institution, give		. 1	4b. Ony	, 10411, 0						_
			Prince Georg  5. Social Security Number 6. Se		a.L. (In yrs. last birthday)	If Unde	r 1 Year	Cheve		. Date of Birth			George's place (State or Foreign ntry)
1	Funeral Director			M_2[ <b>X</b> F	85 Yrs.	Months	Days	Hours	Min.	(Month, Day, 1g. 30,		1 North	n Carolina
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation							10d. Inside City Limits
	the Man 28a-feh notified	rector	Maryland Prince G	eorge's		10f. Zij	Di Code	strict	Hei		0g. Citize	n of What Cou	1 Yes 2 No intry?
	With 38 or	0	1945 Tanow Pla	Ce				2074	<b>.</b> 7		Uni	ted Sta	ates
	death ms 2:	era	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Dece	dent of H			y Yes or No- can, etc.)		Race - Ameri	ican Indian,
920	72 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow kalcal Examiner must be notilied at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:				Specify:	Puerto Hi	can, etc.)	s	Black, White,	, etc. Lack
Baltimore, Maryland 21215-0036		Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+	16a. Dece (Give	denl's Usu kind of wo DO NOT u	al Decup ork done use retired	ation during most d)	of working		16b. Kind	of Business/Ir	ndustry
21	S should be filed withir and Mental Hygiene. Ie marked other than aumatic event, Ine Mental aumatic event, Ine Mental Exemple.	о По	6th_			Oomes	tic	Work				Privat	te
B	be filed tal Hygir d other event,	Be (	17. Father's Name (First, Middle, Last)					18. Mother	's Name (f	First, Middle, M	Aaiden Si	umame)	
<u> a</u>		To	Unkno	wn.					Ţ	Jnknown	l		
Man			19a. Informant's Name/Relationship (7 Hoyle L. Parke			•	,				*	Town, State, Zij MD 207	•
e,	t and the the straight the true the true true true true true true true tru			175011	20b. Place of Dispo	osition (Na	me of	1.0	Dat				
و			1 ☐ Bunal 2 ☑ Cremation 3 ☐	1 ☐ Bunal 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place)									
를	artmer ortant injury			□ Donation 5 □ Other (Specify)  Lee's Crematory 1/16/2007 Clinton, MD  ignative of Funeral Service Licensite  22. Name and Address of Facility Stewart Funeral Home									
Ba	permit. Page Department of Important: If eny Injury or once.		and T. S.	terent T	TI_							., DC 2	
	Physician /Medical Examiner	ıer	23a. Part 1. Enter the disease, or compshock, of heart failure. List only disease or candition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Multi- Due to (or as a	organ dys				cardiac or r	espiratory arre	951,		Approximate Interval Between Onset and Death
68760,	icale be executed physician end s the burial-transit	dicai Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last		ole Liver consequence ol): onia	Mass	es						
P.O. Box 6	Hospital or Attending Physician: The law requires that the death certificate to thours after death. Ya hours after death. Funeral Director: After this certificate has been signed by the attending physically filled in by the funeral director, page 2 should be detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at Ii 9 Unknown	Fetal death 3	⊒Ectopic p ⊒ Other (s <sub>i</sub>					23	d. Date of deliv Month	rery Day Year
of Vital Records, P	uires that n signed b	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	ınderlying	cause giv	en in Part I.			acco use		the cause of death? bably 4 Dunknown
000	w require	Completed								24a. Was a		24b. Were aut	opsy findings available
æ	Physician: The lav r this certificete has ral director, page 2 a	шо								autops perform	ned?	death?	ompletion of cause of
ta	tifice	O U	25. Was case referred to medical					26. Place	ol Death (	Check only on		1	20110
<b>=</b>	ysiciu s cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	t 2 ER/Outpatie	nt 3 D	OA Oth	or				☐Other (Speci	fy)
n of	ing Phy Mer thi		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	28b. Time o		28c. İnjur Wor			d. Describe ho	w injury	occurred	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification;	2 Acciden  investigation 3 Suicide 6 Could not be 4 Homicide determined		y - Al home, farm, st (Specify)	reet, lactor		Yes 2□N		I. Location (St. City or Town		Number or Aur	al Route Number,
	Ne Funeral	Medicai (		ysician: To the best of iner: On the basis of e and manner state	xamination and/or in								
	within To the	ž	29b. Signature and title of certifier	_		29	c. Licens	e number		29		signed (Month,	•
	(3)		M ACK	D			$\mathcal{D}$	61446	9		0	1/5/07	7
	SIC.		30. Name and address of person who a Kalaiselin Ayya		ath (Item 23a) (Type HCSPITAL		HEVE	RLY N	ND 20	785			
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar									

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			_ For	State of Ma	ryland / Dep	partment of H	lealth and M	ental Hygien	e O O O T	01600
			- State Registrar		Ce	ertificate of		Reg. N	102UU1	UIbZZ
	Physici	an	1. Decedent's Name (First, Middle,  Jennie L. Mo	Last) TSE					ay Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death		5 ZOO7 lc. County of Death	
	E.Xaiiiiii	C1	Doctor's Commun		1	Lanham		P	rince Geo	orge
	Funeral		,	. Sex 7. Age 1 □ M 2 🖾 F	(In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	_	place (State or Foreign ntry)
	Director		578-26-8942 Usual Residence of Decedent		88 Trs.			10/17/191	8 Loui	siana
	ryland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
:	89-1-8	Director	Maryland Prince	George	Upper Ma			10- 6	Citizen of What Cou	1⊠Yes 2□No
:	death with the Maryland ms 23a or 28a-f show rmust be notified at	Dir	10e. Street and Number 112 Joyceton Wa	337		10f. Zip Code 20774	* ·		USA	THE Y
	death	Funerai	11. Marital Status	12. Was Decedent E- Armed Forces?	ver in U.S. 13		dispanic Origin? (Spean, Mexican, Puerto F		14. Race - Ameri Black, White	
	or Ite	/ Fur	1 Never Married 2 Married			1 ☐ Yes 2 ☒ No		rican, etc.)		lack
	hours after tural', or Ite al Examina	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	16a Dec	edent's Usual Occup	pation	16b	Kind of Business/li	ndustry
<u>.</u>	within 72 ene. than "na ta Medic	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed)	(Giv	re kind of work done DO NOT use retire	during most of working	ng .		
N	filed with Hygiene other the ent, Ite	Completed		College (1-4or 5+	P	rinter			deral Go	vernment
and	be fill bd oth	Be	17. Father's Name (First, Middle, La Alfonse Morse	st)				(First, Middle, Maide Lee Walmsl	,	
5	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If Health and Mental Hygiene "natural", or Items 23a or 28a-f show titm 21 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, it a Modical Examinar must be notified at	은	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Street	and Number or Rural			p Code)
Ma	and 2 sealth ar n 27 is		Katie M. Morse/I		112	Joyceton	Way, Upper	Marlboro	, MD 20	774
e e	ges 1 a it of He if item or othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	□Removal from State	20b. Place of Dis cemetery, cr	position (Name of ematory or other pla		ate 20c.	Location - City or T	own, State
	Liver and Page		4 ☐ Donation 5 ☐ Other (Spe	icify)			tery 01/09			
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Li	ensee Mill			ess of Facility Fort nsburg Rd			ноте 20722
	-		23a. Part1. Enter the disease, or conshock, or heart failure. List of	omplications that caused the	the death. Do not e				,	Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	Meta	stati	0 6	aNC.	er t	0 /14	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
Е	Examinei	-	Sequentially list conditions,	/						
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Acres	consequence of):	encol	FOIST	Une		
ב ב	te be executed ysicien and he burial-transit		resulting in death) Last	Due to (or as a	consequence of):		V = 0.0			· · · · · · · · · · · · · · · · · · ·
_	ate be hysicianhe bu	lical	13	d						
ρ • •	death cerlificate e attending phy ed for use as the	/Mec	IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d. Date of deliv	YADV
X Q	atten atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 Fetal death 3	☐ Ectopic pregnanc	у		Month	Day Year
j.	ache	by Physician/Med	9 Unknown	9□ Unknown						
<u>'</u>	w requires that been signed b should be deta	by	Part II. Other significant condition	spontributing to death but	t not resulting in the	underlying artuse giv	ven in Part I.	23e. Did tobacco		the cause of death? bably 4 2 Unknown
ecords,		Completed	- POIA O	2111)	10101		<del>)</del>	24a. Was an		opsy findings available
ě	The law ate has b page 2 st	id m						autopsy performed?	prior to co death?	ompletion of cause of
			25. Was case referred to medical				26. Place of Death	(Check only one)	No 1 □ Yes	2LJ N0
<u> </u>	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Outpati	GERT SEL DOM		ne 5 Residence		fy)
č	ding P h. After t funera	ion	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wo	ryat 2 rk?  Yes 2 □No	8d. Describe how in	jury occurred	
DIVISION	Attender death actor: by the	ficat	2 Accident investiga 3 Suicide 6 Could no	t be 290 Place of Injur	ry - At home, farm,	street, factory, office		8f. Location (Street		al Route Number,
2	al or setter setter al Dire	Certification:	4 Homicide	building, etc.	. (Specify)			City or Town, Sta	10)	
	To the Hospital or Attending Physician: within 24 hours elfer deals to the Funeral Director: After this certific completely filled in by the funeral director,		(Check only 2 Medical E.	Physician: To the best of caminer: On the basis of	examination and/or	ath occurred at the ti	me, date and place, a ppinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	thin 2, the P	Medicai	one) 29b. Signature and title of certifier	and manner stat	ted.	29c. Licens	se number	29d. E	Date signed (Mogiti	Day, Year)
	3 3 8		The Troppe			90	05844	6 1	15/à	200+
	6		30 Name and address of person v	no completed cause of de	eath (Item 23a) (Typ		100 17	0 1 1	, 0/	20706
	SIC		Kovalchu	e rade	nzda.	M 7 81	18 Good Lu	ick Rd., L	anham, M	20706
	Sta	ite	31. Date filed (Month Day, Year)	32. Registra	The state of the s					

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Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give street and number)  Casey House  4b. City, Town, or Locat Rockville  Funeral  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Medical Medical  Application  1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give street and number)  Application  4b. City, Town, or Locat Rockville  Funeral  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Medical Medical  Medical  Application  Application  Medical  Application  Applicat	2. Date of Dea	eg. No. 1 1 0 2 3							
Examiner  4a. Facility Name (If not institution, give street and number)  Casey House  4b. City, Town, or Locat  Rockville	Month	th 3. Time of Death							
	ution of Death	4c. County of Death							
	Inder 24 Hrs. 8. Date of Birth	Montgomery  9. Birthplace (State or Foreign							
Director 311-16-0757 1 2 F 90 Yrs. Wolfins Days Hot.	ours Min. Oct 17,	1916 Indiana							
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits							
Maryland Montgomery Bethesda		1 □Yes 2¶ No							
10a. State 10b. County 10c. City, Town or Location  Maryland Montgomery Bethesda  10c. Street and Number 5808 Wilmett Road  10c. Street and Number 5808 Wilmett Road  10c. Street and Number 5808 Wilmett Road  11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? 12 Woo If Yes, Give Year or Dates:  11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? 12 Woo If Yes, Give Year or Dates:  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mei Yes are or Dates:  13. Was Decedent of Hispanic If Yes, Specify Cuban, Mei Yes are or Dates:  15. Decedent's Education (Give kind of work done during life. Do NOT use retired)  16a. Decedent's Usual Occupation (Give kind of work done during life. Do NOT use retired)  17. Father's Name (First, Middle, Last)  18. Maryland Montgomery  10c. City, Town or Location  Bethesda  10f. Zip Code  20817-2521  11. Was Decedent of Hispanic  11. Yes, specify Cuban, Mei Yes, specify Cuban, Mei Yes, specify Cuban, Mei Yes, specify cuban		log. Citizen of What Country? USA							
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.							
1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Spe	ecify:	Specify: White							
The state of the s	most of working	16b. Kind of Business/Industry							
Some state of the		Federal Government							
Tr. Father's Name (First, Middle, Last)  John Almon Martin  18. M  Dai	Mother's Name <i>(First, Middle, i</i> isy Morehouse	Maiden Surname)							
John Almon Martin  19a. Informant's Name/Relationship (Type. Print)  Frances F. Martin/wife  20a. Method of Disposition  20b. Place of Disposition (Name of	d Bethesda, MD	r, City or Town, State, Zip Code)							
JOHN Almon Martin  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and No. 5808 Wilmett Road  20a. Method of Disposition  1 Burial 2 Extremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Chesapeake Crematory  21. Signature of Funeral Service Licensee/  3 Name and Address of Funeral Service Licensee/	i	20c. Location - City or Town, State Beltsville, MD							
21. Signature of Funeral Service Licensee/  21. Signature of Funeral Service Licensee/  32. Signature of Funeral Service Licensee/  33. Signature of Funeral Service Licensee/		ce P.O. Box 784							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such		Clarksville, MD 21029							
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Aspiration Pneumonia		Interval Between Onset and Death							
/Medical resulting in death)  Due to (or as a consequence of):  Examiner  Demonstria, not otherwise, executifications and the provided executions and the provided executions are also as a consequence of the provided executions are also as a con	iod								
Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause, (Disease or injury)									
path of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):									
between the care of the control of the care of the car									
		23d Date of delivery							
		23d. Date of delivery Month Day Year							
23c. If yes, outcome pf pregnancy  1		Month Day Year bacco use contribute to the cause of death?							
The market in the past 12 months?  23c. If yes, outcome pf pregnancy 1 \[ \] \	1 ☐ Yo	Month Day Year  bacco use contribute to the cause of death?  es 2 ☑ No 3 ☐ Probably 4 ☐ Unknown  24b. Were autopsy findings available							
The market in the past 12 months?  23c. If yes, outcome pf pregnancy 1 \[ \] \	1  Your 24a. Was a autops perfor	Month Day Year  bacco use contribute to the cause of death?  es 2 ☒ No 3 ☐ Probably 4 ☐ Unknown  24b. Were autopsy findings available prior to completion of cause of							
The market in the past 12 months?  23c. If yes, outcome pf pregnancy 1 \[ \] \	1  Yes 24a. Was a autops perform 1 Yes 2	Month Day Year  bacco use contribute to the cause of death? es 2 № No 3 □ Probably 4 □ Unknown  n 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No							
23c. If yes, outcome pf pregnancy 1 \subseteq 12 \subsete	24a. Was a autops perform 1 Tyses  Place of Death (Check only on Some South Reside 128d. Describe here)	Month Day Year  bacco use contribute to the cause of death?  es 2 ☑ No 3 ☐ Probably 4 ☐ Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No							
23c. If yes, outcome pf pregnancy 1 \subseteq 12 \subsete	24a. Was a autops perform 1 Yes  Place of Death (Check only on Standard Properties)  Nursing Home 5 Reside 28d. Describe he 2 No 28f. Location (Standard Properties)	Month Day Year  bacco use contribute to the cause of death?  es 2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  ence 6 Nother (Specify) hospice  by injury occurred							
23c. If yes, outcome pf pregnancy 1	24a. Was a autops perform 1   Yes   Place of Death (Check only on   Nursing Home   5   Reside   28d. Describe he   2   No   28f. Location (St. City or Town	Month Day Year  bacco use contribute to the cause of death? es 2 ☒ No 3 ☐ Probably 4 ☐ Unknown  24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No  ence 6 ☒ Other (Specify) hospice  by injury occurred  treet and Number or Rural Route Number, 1, State)							
23c. If yes, outcome pf pregnancy 1	24a. Was a autops perform 1 Yes  Place of Death (Check only on 28d. Describe house 2 No 28f. Location (St. City or Town ate and place, and due to the coate of th	Month Day Year  bacco use contribute to the cause of death? es 2 ☒ No 3 ☐ Probably 4 ☐ Unknown  24b. Were autopsy findings available prior to completion of cause of death? 2☐ No  1☐ Yes 2☐ No  ence 6 ☒ Other (Specify) hospice ow injury occurred  treet and Number or Rural Route Number, n, State)							
23c. If yes, outcome pf pregnancy   1	24a. Was a autops perform 1 Yes  Place of Death (Check only on 28d. Describe house 2 No 28f. Location (St. City or Town ate and place, and due to the con, death occurred at the time, determined the course of the	Month Day Year  bacco use contribute to the cause of death? es 2 ☑ No 3 ☐ Probably 4 ☐ Unknown  24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No  ence 6 ☒ Other (Specify) hospice  by injury occurred  treet and Number or Rural Route Number, 1, State)  ause(s) and manner as stated. late and place, and due to the cause(s)  19d. Date signed (Month, Day, Year)							
23c. If yes, outcome pf pregnancy   1	24a. Was a autops perform 1 Yes  Place of Death (Check only on 28d. Describe house 2 No 28f. Location (St. City or Town ate and place, and due to the con, death occurred at the time, determined the course of the	Month Day Year  bacco use contribute to the cause of death? es 2 ☑ No 3 ☐ Probably 4 ☐ Unknown  24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No  ence 6 ☒ Other (Specify) hospice ow injury occurred  treet and Number or Flural Floute Number, 1, State)  ause(s) and manner as stated. late and place, and due to the cause(s)							
23c. If yes, outcome pf pregnancy   1	24a. Was a autops perform 1   Yes   Place of Death (Check only on   Nursing Home   5   Reside   28d. Describe he   28f. Location (Sicily or Town ate and place, and due to the con, death occurred at the time, death occurred at	Month Day Year  bacco use contribute to the cause of death?  es 2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Pes 2 No  1 Pes							

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Spark

			1- State of Maryland / Department   Registrer	ent of Health and Nate of Death	-	2007	01624				
			Decedent's Name (First, Middle, Last)		2. Date of Dea		3. Time of Death				
	Physici /Medic		RICHARD W. MILLER		JAN. 05	Day Year 2007	11:00 M				
	Examin		4a. Facility Name (If not institution, give street and number) 4b. C	ity, Town, or Location of Death	)	4c. County of Dea	ith				
				arlotte Hall	8. Date of Birt	St. Mary	S tholans (State or Somine				
	Funeral Director		578-20-0685 1 Mar 2 F 83 Yrs. Montt		10-06-	1 0°3′3   C	thplace (State or Foreign ountry)				
	p.		Usual Residence of Decedent			De	rwyn, Marylan				
	ehow	ř	10a. State 10b. County 10c. City, Town or Location  Maryland St. Mary's Charlotte	На11			10d. Inside City Limits 1 ☑ Yes 2 ☐ No				
	the M	Directo	narytana see nary s	Zip Code		10g. Citizen of What C					
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ad other then "natural", or items 23s or 28s-f show do other then "natural", or items 23s or 28s-f show event, the Madical Examinar must be notilised at		29449 Charlotte Hall Road	20622		rog. Citizen of What C	outiny:				
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	ecedent of Hispanic Origin? (S	pecify Yes or No-						
õ	or its		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	specify Cuban, Mexican, Puerti s ŽTNo Specify:	o Hicari, etc.)	Black, Whi					
9500-61212	hours urai',	d by	33 4 Vidowed 4 □ Divorced Year or Dates:	m l'es 1		Specify: wh					
Ç	within 72 ene. then "nat	olete	life DO NO	Isual Occupation work done during most of work Tuse retired)	king	16b. Kind of Business	/Industry				
717	d with piene.	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	ispatcher		Private I	ndustry				
-	be filed ital Hygie id other	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle,	Maiden Sumame)					
<u>a</u>	Menta Menta Brked	To	Thomas L. Miller	Lorrain	e Wheele	r					
Maryland	es 1 and 2 should to of Health and Ment of Item 27 le marked r other traumatice		V Commence of the Commence of	ress (Street and Number or Ru			Zip Code)				
	1 and Health em 27 ther t		Grace Marion MacKinnon/dau. 2132 Lob1  20a. Method of Disposition 20b. Place of Disposition //	lolly Lane St.	Leonard,		Tour State				
Š	Pages nent of I int: If its ary or o		1 Rusial 32 Cramation 3 Removal from State   cemetery, crematory c	or other place) ark Crem. 1-08		20c. Location - City or Riverdale,					
Baltimore,				and Address of Facility	2007	Riverdate,	1144				
ñ	permit. Depertumporti		Ca Marker 3 Cedar	r Hill FH 4111	PA Ave.	Suitland,	Md. 20746				
			23d. Pahr. Enter the disease, or compressions that caused the death. Do not enter the n shock, or heart failure. List only one cause on each line.	node of dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between				
1	Physician		Immediate Cause (Final disease or condition a. Asp.: atam premises the premises of the premise	7			Onset and Death				
	/Medical Examiner		Due to (or as a consequence of):				Zweeks				
	LXammer	_		no phania			5 years				
	nsit	nlner	cause. Enter Underlying Cause (Disease or injury								
	execu n and al-tra	Examin	that initiated events resulting in death) Last c	_=							
8/60	cate be executed physicien and the burial-transit	dical	d								
	ng phy as th	Medi	IF FEMALE.								
X Q Q	death certiff e ettending id for use as	an/h	IFFEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic	c pregnancy		23d. Date of de					
9	at the death certific by the ettending parached for use as	Physician/Me	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other 9 Unknown	(specify)		Month	Day Year				
2	that the		Part II. Other significant conditions contributing to death but not resulting in the underlyin	or cause given in Part I	23e. Did to	bacco use contribute to	o the cause of death?				
Hecords,	The law requires that te has been signed b	d by	Alzheiner's dementia	g dadd grown arra			robably 4 □Unknown				
Ö	w require been sign	lete			24a. Was	an 24h Were a	utonsy findings available				
Ĕ	sician: The law certificete has b irector, page 2 s	Completed			autop perfor	sy prior to med? death?	utopsy findings available completion of cause of				
Vital		Bec	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes	/-	3 2/⊠ No				
o	A	To	examiner? 1 Tes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	Othor	- 10 m	ence 6 ☐Other (Spe	ecify)				
<u> </u>	ding Ph h. After th funeral	on:	27. Manner of Death 28a. Date of Injury 1 SNatural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred					
Division	ttend death stor: / the f	Icat	2 Accident investigation 3 Suicide 6 Could not be	1 Tes 2 No	29f Lacation (C	446					
2	efter Direc	Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide	тогу, опісе	City or Tow	treet and Number or R n, State)	ural Houte Number,				
	Hospital or At     24 hours efter o     Funeral Direct etely filled in by		29a. Certifier 18 Certifying Physician: To the best of my knowledge, death occurr	red at the time, date and place,	and due to the o	ause(s) and manner a	s stated.				
	To the Hospital or Attending I within 24 hours efter death.  To the Funerel Director: After completely filled in by the funer	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigate and manner stated.	ion, in my opinion, death occur	rred at the time, o	date and place, and due	e to the cause(s)				
	To the	Σ	29b. Signature and title of certifier	29c. License number	4	9d. Date signed (Mon					
	11)		Carrie / C	D0061882		01-05-2	-007				
	gc		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	arlotte Hall R	d. Char1	otte Hall.	Md. 20622				
÷,	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	222000 10022 11							
	Registr		JAN 1 0 2007 Barry My Jacks								

DHMH 17 Rev 1/2001

			1 - For State of Registrar	Maryland / Dep	partment of Fertificate of			7 11 1	7	016	25
	ē	rite in the	Decedent's Name (First, Middle, Last)		ortinoato or	Douin	2. Date of De	Reg. No.		3. Time of I	Death
	Physici		ADROTHY Mari	E MCNI	EW		Month January	2 s 200	Year 7	1:45	P <sup>M</sup>
	/Medic Examin	46	4a. Facility Name (If not institution, give street and num.			or Location of Deat		4c. County		1.45	
			Wilson Health Care Center	c	Gaithe	rsburg		Montgo	omerv	7	
	Funeral			. Age (In yrs. last birthda			8. Date of Bir	th	9. Birtho	lace (State or	Foreign
40.	Director		166-16-3135 <sup>1□M 2</sup> TF	87 Yrs.	Months	riodis Will.	Dec. 2	2,1919	PA	uy)	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location					0d. fnside Cit	v Limite
	Aaryli r sho	ō	MD Montgomery		nersburg					1 X Yes	•
	28a-	Director	10e. Street and Number	Care	10f. Zip Code			10g. Citizen of W	that Cour		
	Sa or		301 Russell Ave.			877		United S		•	
	me 2;	Funerai	11. Marital Status 12. Was Deced	ent Ever in U.S. 13			specify Yes or No			an Indian,	
ω	r ite		Armed Force  1 Never Married 2 Married 1 X Yes 2  If Yes, Give	es?	3. Was Decedent of F ff Yes, specify Cub		to Rican, etc.)	Blac	k, White,	etc.	
93	72 hours after death with the Maryland natural; or iteme 23a or 28a-f show dical Examilian mail to incillian al	by	3X Widowed 4 □ Divorced If Yes, Give Year or Dat	es: WWII	1 ☐ Yes 2 X No	Specify:		Specify	Whi	te	
21215-0036	d within 72 hours after death with the Marylan jene. r than "natural", or iteme 23s or 28s-f show the Modical Exaction or most to relified at	Completed	15. Decedent's Education (Specify only highest grade completed)		cedent's Usuaf Occup ve kind of work done		rkina	16b. Kind of Bu	siness/ind	dustry	
21	within iene. than "	idu	Elementary/Secondary (0-12) College (1-	for 5+)	. DO NOT use retire	d)	9				
2	il Hygier other th		4	Home	emaker		feet a second	Own Ho			
and	d la b	Be	17. Father's Name (First, Middle, Last) William E. Hesselbache:	_				. Maiden Sumam	θ)		
Z Z	should be nd Mental marked c	2	19a. Informant's Name/Relationship (Type, Print)		11 Add (Ot		rite Dow		O		
Maryland	S 80 50		Bruce McNew (Son)		Wawaset D						
	1 and 2 Health tem 27 l		20a. Method of Disposition	The second secon	position (Name of rematory or other place	T.	Date	20c. Location -			
JO L	0 0		1 Surial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	ialo	rematory or other pla e Veterans		2007	Bear, D			
Baltimore,	Department Department mportant: I mny injury o	1	21. Signature of Funeral Service Licens	1	22. Name and Addre	4		•		are	
Ba	permit. Departrimporta		Custin & Kay		lO East De					20877	,
200	£°		23a. Part1. Enter the disease, or complications that ca	used the death. Do not e					,	Approximate	)
E	Physician		shock, or heart failure. List only one cause on ea fmmediate Cause (Final		Oux et	77xi	120			Onset and D	eath
	/Medical		disease or condition resulting in death)  a. Due to (or provided in the condition of the co	r as a consequence of):	luret.	1,7000	~ _			where	niu
	Examiner		Sequentially list conditions h	lvune	edde	man	etia				
2	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r as a consequence of):						-	
	ecute and -trans	Examine	triat initiated events								
8760,	be executed sicien and burial-transit		Due to (o	r as a consequence of):							
87	ate the	Physician/Medical	d								
9 X	nding p	/Me	fF FEMALE: 23c. ff ves. outc	ome of pregnancy				004.5-4	6 - 4 - 15		
Box	atten for u	cian	in the past 12 months?	th 2 Fetaf death 3	B Ectopic pregnance	у		23d. Date Mor	of deliventh	,	'ear
0	fhat the d ed by the detached	ysi	1 ☐ Yes 2 ☑ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown		Z Gillor (opcony) _						
٦,		by PI	Part ff. Other significant conditions contributing to dea	th but not resulting in the	underlying cause gr	ven in Part f.	23e. Did t	obacco use centr	bute to th	e cause of de	eath?
Records,	quires nn sign uld be	a b	Coronaryarter	y discar	ce. Hy	urteur	in 10	Yes 2 No	3 🗌 Prob	ably 4 □U	nknown
ပ္ထ	aw requir as been s 2 should	Completed	Hyperlipidene	ea. Osta	eparos	ixi	24a. Was	an 24b. V	Vere auto	osy findings a	vailable
Ä	0 - 0	E	Hartomia Ane	min elch	Junice	Lines		rmed?/ d	eath?	npletion of ca	use of
Vital	ician: Th certificete rector, pag	Be C	25. Was ase referred to medical	The good		26. Place of Dea	ath (Check only o		162	ZL NO	
<u>_</u>	5 S	70	examiner? 1 Yes 2 No Hospital: 1 In	patient 2 ER/Outpati	ient 3 DOA Ott	ner: 4 Nursing H	lome 5 Resid	dence 6 Othe	er (Specify	<i>'</i> )	
n of			27. Manner of Death 28a. Date of 1 Natural 5 Pending (Month	fnjury 28b. Time Day Year) fnjury		ry at rk?	28d. Describe l	now injury occurr	be		
sio		cati	2 Accident investigation			Yes 2 No					
Division	i ji te	Certification:	determined 286. Place of	of fnjury - At home, farm, g, etc. <i>(Specify)</i>	street, factory, office		28f. Location (: City or To	Street and Numbe vn, State)	er or Rura	l Route Numb	⊅ <i>07</i> ,
	Hospital		29a. Certifier 1 Vertifying Physician: To the I								
	Fur Fur stely	Medicai	29a. Certifier (Chook only one)  1 Vertifying Physician: To the to a manner. On the base and manner.	sis of examination and/or	ath occurred at the til investigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed	(Month,	Day, Year)	
1	ofi		Maple this	1 , Cm	1. 00	4115		lu		3 200	7/7
· (			30. Name and address of person who completed cause	of death (ftem 23 (Typ	-10]		52/1/22	1181111	sej ~	- Jack	- /
			14. ROBERT BIRSCH	BARHIM	0. GA	-THERS	SELLA	nes à	208	74	
板	Sta	ite		gistrar's Signature							
	Regist	rar	JAN 0 8 2007	eve & A	berle						

		- State Registrar		Certificate of L	Peath	Reg	No.		
Obs. et et		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Ye	ar	3. Time of Death
Physici: /Medic	-	Susan Anr	n Morri	111		January 1		ad i	3:42 P
Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or		Salidal y	4c. County of [	Death	U.TA I
LXdiiiii	٠.	Calvert Memorial	Hospital	Prince	Frederic	k	Ca	lve	rt
F		5. Social Security Number 6. Sep			If Under 24 Hrs.	8. Date of Birth			
Funeral Director		10	M 2XIF	Yrs. Months Days	Hours Min.	(Month, Day, Y	ear)	Count	ace (State or Foreig ry)
Director		548-19-7464 Usual Residence of Decedent	45			July 6,	1961	all	fornia
and and		10a. State 10b. County	10c. City, Town	n or Location				10	d. Inside City Limit
any	ក								1 XYes 2 No
- 88 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	9ct	MD Calvert C	County North	Beach					
1 0 M	吉	10e. Street and Number		10f. Zip Code		109	. Citizen of Wha	t Count	ry?
within 72 hours atter death with the Maryland ene. Than "natural", or Itama 23a or 28a-f ahow he Medical Examiner must be notified at	Funeral Director	3905 6th Street		20714			U.S.A.		
9	ne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of His If Yes, specify Cubar</li> </ol>	panic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race Black, \		
or it	正	1 Never Married 2 Married	1 ☐ Yes 2 💢 No If Yes, Give	1 ☐ Yes 2 ☒ No	Specify:	, ,			
ours	qp	3 ☐ Widowed 4 ₹ Divorced	Year or Dates:		oposy.		Specify:	11111	Le
72 n natu	Completed	15. Decedent's Edu (Specify only highest grade		Decedent's Usual Occupa	tion	16	b. Kind of Busin	ess/Ind	ustry
F 2 2	힐	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done di life. DO NOT use retired)	string throat of tront.	···			
E COM	듓	11		Caretaker		2	State Go	ver	nment
a the	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	iden Sumame)		
d ke d o	To B	Charles Morrill			Jean	Grannatt			
Shou That		19a. Informant's Name/Relationship (Ty	rpe, Print) 19b	. Mailing Address (Street a	nd Number or Rura	l Route Number, C	ity or Town, Sta	te. Zip (	Code)
th a		Alorria Ann Townson	ad (Danahtan) I	O Por 450	Nowth D	oooh Mos	wrland C	0071	1
Hee than		Alexis Ann Townser  20a. Method of Disposition		Disposition (Name of			c. Location - Cit		
or o		1 ☐ Burial 2 X Cremation 3 ☐ P	Removal from State	y, crematory or other place		4			
Tant Tant		4 ☐ Donation 5 ☐ Other (Specify)	Lee C	Crematory	1	2007	Clinton,		-
permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heelth and Mental Hygiene. Inspertment of Heelth and Mental Hygiene. In a first and 28 a or 28a-1 ahow any injury or other traumatic event, the Medical Exeminar must be notified at ODGs.		21. Signature of Fu on Espa Licens	88	22. Name and Address	of Facility Lee	Funeral	Home Ca	lve	rt. P.A.
70 E = 9		MISTELL W. I	Je .	8125 Southe	ern Marvl	and Blvd.	. Owing	s.	MD 20736
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death. Do not cause on each line						Approximate Interval Between
Physician		Immediate Cause (Final	1	\	- (	1 0	7		Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequence	ngocaso	ial	-towet	Noi	-	
Examiner			d	1-1	1	.5.2.			
	10	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	Jed 2 11 11	CAS L	Diseas	<u></u>	+	
ted 1sit	<u>u</u>	cause. Enter Underlying Cause (Disease or injury			1				
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licate be executed physicien and s the burial-transit	edical Examiner		20 to (or as a sortestastic)	5.7.					
physi the t	lice		d						
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S D S		IE FEMALE:							
E 10		23b. was decedent pregnant	23c. If yes, outcome of pregnancy	3 Ectopic pregnancy			23d. Date o		
death certil ie attending ed for use a			1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date o Month		y Day Year
t the death by the atten ached for u		23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death						
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Rudolph Michael		Vak 1- For State	State of Maryla				Mental H	Hygiene	2.0	07 0162
Physicia		Registrar  1. Decedent's Name (First,	Middle Last)	Ce	rtificate of	Death		2. Date of Dear	eg. No. 💴 💛	3 Time of Death
Medical Exami		RUDOLPH M	ICHAEL NO	VAK				Month January 1		1000 hrs
		4a. Facility Name (if not ins Washington Cour		ımber)	4	b. City, Town, or L Hagerstown	ocation of Dea		4c. County of Washingt	
Funeral		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24H	rs 8 Date of Bir		Birthplace (State or
Director		274-70-6655	1 X M 2 F	44	Yrs.	Months Days		n.	8, 1962	Foreign OHIO
×		Usual Residence of Decede	ent					111011	0, 1302	
now any				10c. City	, Town or Locati		DVCVIII	_		10d Inside City Limits 1 Yes 2 X No
arylan 8a-f sh at onc	Director	MARYLAND W  10e. Street and Number	ASHINGTON			10f. Zip Code	DYSVILI		0g Citizen of Wha	
ith the Maryland 23a or 28a-f show notified at once.		4812 PORTER	STOWN ROAD				217	756		U.S.A.
th with	Funeral	11 Marital Status 1 X Never Married 2	12. Was Dec	cedent Ever in U		Decedent of Hisp es, specify Cuban,			14 Race - White	American Indian, Black, etc.
ter dez		3 Widowed 4	1 Yes Divorced If Yes, Give Yea	2 <b>X</b> No	1	Yes 2 X No	specify:		Specify.	WHITE
ours a	d by	15. Decedent's Education	(Specify only highest grad	de completed)	16a. Deceden	's Usual Occupation	on (Give kind of	work done	16b. Kind of Busi	
36 in 72 h han "r	ompleted	Elementary/Secondary (	,	1-4 or 5+)				urea)	555	DDEAKEACT
5-0036 led within 7 Hygiene other than	Com	17. Father's Name (First, M	iddle, Last)		J CO-01	INER & OP		ne (First, Middle, N	Maiden Surname)	& BREAKFAST
1215 be file ontal H irked o	æ	RUDOLPH EMIL				D	OLORES	JOYCE LI	UPO	
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene and tent of Health and Mental Hygiene and I friem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medreal Examiner must be notified at once.	유	19a Informant's Name/Rela			1.7				nber, City or Town,	
e, MD 1 and 2 sh Health and item 27 is	H	MARK SVRCEK/ 20a. Method of Disposition			Place of Disposi	tion (Name of cem-		Date	YSVILLE, 20c. Location - C	MD 21756 Dity or Town, State
Baltimore, semit Pages Lar Department of Hei Important: If ite	П	1 X Burial 2 Cren 4 Donation 5 Oth		om otato	crematory or oth	er place) S CEMETE	DV 1/2	20/2007	IDDOOK DA	ARK, OHIO
Baltimo permit Page Department co Important: injury or oth	-1	21 Signatu e il uneral Se	rviya Licensee		22. N	ame and Address of	of Facility	7606 0		onal Pike
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Physician /Medical		failure. List only one of	ause on each line.			cular disea		or respiratory arre	est, snock, or near	Approximate Interval Between Onset and Death
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0, e be executed sician and burial - transi	edical	X UNPENDED	AMENDED	#23a.27.1	perME. 280	53, 1/29/07	, TT			
	ian/Me	IF FEMALE: 23b. Was decedent pregnan	t in the 23c. If yes, o	outcome of preg	nancy				23d Date of de	
Box 6876( ne death certificate r the attending physeled for use as the b	sicial	past 12 months?	4 Pregn	ant at time of de	ath _	al death 3 er (Specify)	Ectopic pregr	iancy	Month	Day Year
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ires that the signed by	百	Tana a sa	mentorio contributing to	death but not n	esuring in the u	idenying cause giv	/enin Pait i			Probably 4 Vunknown
Division of Vital Records, rat or Attending Physician: The law requirers after cleath and Director: After this certificate has been sited in by the funeral director, page 2 should the	Completed							24a Was a		ere autopsy findings available
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tal Rection: The certificate ector, page	BeC	25. Was case referred to me examiner?					of Death (Check			
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ivision or Attencatter death Director:	Certification:	2 Accident 3 Suicide 6	Investigation Could not be 28e. Place	e of Injury - At h	ome, farm, stree	, factory, office bui	ilding, etc.			or Rural Route Number, City
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Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate writin 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	edical	(Check only Certify)	ng Physician: To the bes I Examiner:On the basis of	of examination a	ge, death occurr ind/or investigati	ed at the time, date on, in my opinion, o	e and place, and death occurred	d due to the cause at the time, date a	e(s) and manner at and place, and due	s stated to the cause(s)
To COM	Me	29b Signature and title of c	ertifier and manner si	tated		29c License				(Month, Day, Year)
		Ling	av, mi	>		O.C.M	LE.		January 16,	2007
	Ì	30. Name and address of pe				Politica : 14	ID 04004			
91:	ate	Ling Li, MD Ass	sistant Medical Exar	miner 111 estrar's Signatu		, Baltimore, M	10 21201			
Regist	rar	JAN	17 2007	Brevar	B. Apr	cite				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Frank Samuel Nese 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1XM 2□ F Days Yrs 78 Director 220-18-1704 May 28 1928 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 'natural", or Items 23a or 28a-f show di-al Examiner must be notified at Director 1 ☐ Yes X☐ No Marvland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13524 Cherry Tree Circle 21742 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔯 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Truck Mfg. 10 Stationary Engineer permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event. ## 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francie Ponsari Salvatore Nese ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13524 Cherry Tree Circle Hagerstown Maryland 21742 Jane Rosalie Nese (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-10-2007 Hagerstown Maryland Rose Hill Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LZ DAYS /Medical Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-tra Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: se If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for L in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9□Unknown 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has page 2 perform 20 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: 28c. Injury at Work? the Hospital or Attending I hin 24 hours after death. 1 Natural 5 Pending investigation Injury the Funeral Director: After an Indicately filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 a) (Type, Print) 30. Name and address of cause of death (Ite) 1130 Opal Court 5H-12 Howartown 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

07-00110 Bobot E. Nach	la.	Please Type or Print in B	ack Ir	ndelible Ink. Ensure All Cop	ies Are Le	gible.
Robert E. Nash	, Jr.	State of Maryland		artment of Health and Mental i rtificate of Death	Hygiene	2007 0162
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)	Ce	Tillicate of Death	2 Date of Dea	eg. No
Medical Exam		Robert E. Nash, Jr.			Month January 4	Day Year
		4a. Facility Name (if not institution, give street and number)		4b City, Town, or Location of Dea		4c. County of Death
		5. Social Security Number 6. Sex 7. Ag		Cambridge		Dorchester
Funeral Director		216 56 1007	6 (In yrs. 1			th (MM/DD/YYYY) 9 Birthplace (State or
		Usual Residence of Decedent		Yrs	Julie	18, 1950 Country Maryland
v any		10a. State 10b. County	10c. City	, Town or Location		10d Inside City Limits
Maryland  28a-f show any d at once.	호	Maryland Dorchester		Cambridge		1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once,	Director	10e. Street and Number		10f. Zip Code	11	0g. Citizen of What Country?
h with th	<u>a</u>	5060 Hayland Acres Rd.  11. Marital Status 12 Was Decedent	Ever in III	.S. 13. Was Decedent of Hispanic Origin? (	0	USA
Signal Beath	Funeral	1 Never Married 2 Married Armed Forces?		If Yes, specify Cuban, Mexican, Puer	specify Yes or No to Rican, etc.)	<ul> <li>14 Race - American Indian, Black, White, etc.</li> </ul>
after	by F	3 Widowed 4 Divorced If Yes, Give Year		1 Yes 2 No specify		Specify: White
hours after "natural",	ted	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5		16a. Decedent's Usual Occupation (Give kind o during most of working life. DO NOT use re	of work done	16b Kind of Business/Industry
336 thin 72 than '	Completed	Elementary/Secondary (0-12) College (1-4 or 9	o+)	Correctional Officer	,	Law Enforcement
5-0( led wi Hygier other		17. Father's Name (First, Middle, Last)		<u></u>	me (First, Middle, N	
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygene marked other than "natural", or items 23a or 28a-f shot event, the Medical Examiner must be notified at once	) Be	Robert Earle Nash, Sr.  19a Informant's Name/Relationship (Type, Print)			se Mary 1	
	2	Rose Mary Hamilton/Mother		19b Mailing Address (Street and Number of 51 Park Lane, East	r Rural Route Num	
re, MD 2 I and 2 shoul Health and M Fitem 27 is m	er 10	20a Method of Disposition	20b. I	Place of Disposition (Name of cemetery	Date	21601 20c. Location - City or Town, State
= 0 % = 1		1 Burial 2 Cremation 3 Removal from Sta 4, Donation 5 Other Specify	te Mic	crematory or other place) dShoreCremationCenter	1/10/200	
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other tranmari		21/Signature of Funeral Service Licensee		22 Name and Address of Famility		
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/Medical		Termina Elocating Elocating Control of Control		. Do not enter the mode of dying, such as cardiac	or respiratory arre	Between Onset and
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	nine	if any, leading to immediate cause. Enter Underlying Cause	quence of	f):		
ed 13i	Examiner	(Disease or injury that initiated events resulting in death) Last    Due to (or as a conse	quence of	f):		
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ox 68760, ath certificate be attending physic or use as the burn	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3 Ectopic pregr	nancy	23d Date of delivery  Month Day Year
Box 68760, death certificate be he attending physicide for use as the buri	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown	ime of de	ath 5 Other (Specify)		
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cords law requi	plet				24a. Was a autops	- I reve watered intallige available
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Vital Reovision: The his certificate director, page	Be	25. Was case referred to medical examiner?		26 Place of Death (Check		
n of Vir tling Physic After this funeral dir	입	1 Yes 2 No Inpatier 27. Manner of Death 28a. Date of Injur				Residence 6 Other Scene
Sion C Attending death. ctor: Af y the fun	tion	1 Natural 5 Pending (Month, Day, Ye	ar)	28b Time of Injury 28c. Injury at Work?  1 Yes 2 No	280. Describe hi	ow injury occurred
Division of Vital Records, the law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inju	ıry - At ho	me, farm, street, factory, office building, etc.	28f. Location (St	treet and Number or Rural Route Number, City
Divis pital or At ours after d teral Direct filled in by	Cert	4 Homicide determined (Specify)			or Town, Sta	ate)
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for ur		29a Certifier 1 Certifying Physician: To the best of my one)	knowledg	e, death occurred at the time, date and place, and	d due to the cause	e(s) and manner as stated.
To the within To the comple	Medical	29b \$ignature and the of certifier.	mation ar	nd/or investigation, in my opinion, death occurred		
			$/\!/L$	O.C.M.E.		29d Date signed (Month, Day, Year)
	-	30 Name and address of person who completed cause of de	ath (Item	1		January 5, 2007
		Susan Hogan MD. Assistant Medical Ex		111 Penn Street, Baltimore, MD 21	1201	
St Regist	ate rar	31 Date filed (Month Park YOr) 8 2007 32 Figistrar	s Signatur	A Speeds		
(MM1777)av 50			- /	OPIGINAL		
OCME 2006				ORIGINAL		

07-00110

State of Maryland / Department of Health and Mental Hygiene > 1 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** January 2, 8:05 p M Neak 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number If Under 1 Year | If Under 24 H Months | Days | Hours | Mi Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🖺 F Director 577-06-3679 107 2, 1900 Jan. Cambodia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 No Director Marvland Wheaton Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or Items 23a 3510 Weller Road 20906 Cambodia Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 Tyes 2€ No. Specify þ Specify: Asian 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other termines. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown 2 Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bin Song/ Daughter 3510 Weller Road, Wheaton, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State January 6 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22-Name and Address of Eachily lins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Heav **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe ospital or Attending Physician: 1 hours after death.
uneral Director: After this certificat y filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manno of Death 1. Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide io the Ho.
within 24 hours.
To the Funeral D'
'etely filler' 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and tine of certified MD address of person who completed cause of death (Item 23a) (Type, Print) IWD 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 05 Registrar

				partment of Health and Menta	Reg. No. 007 01631
	Physici	an	Decedent's Name (First, Middle, Last)	2. Dat Mo	e of Death nth Day Year 3. Time of Death
	/Medic	al	Lois Jean Norris  4a. Facility Name (If not institution, give street and number)	Janu 4b. City, Town, or Location of Death	uary 4, 2007 3:55 P.M.
	Examin	ier	Montgomery General Hospital	Olney	Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	/) If Under 1 Year If Under 24 Hrs. 8. Dat	e of Birth 9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	Dece	ember 15, 1945Massachusetts
	yland now		10a. State 10b. County 10c. City, Town or I	_ocation	10d. Inside City Limits
	a-1sh	ctor	Maryland Montgomery Damascu	IS	1 □ Yes 2/□ No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	eath v	erai	9829 Moyer Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin 2 (Specify Vo	U.S.A. s or No- 14. Race - American Indian,
<b>'</b> O	fter d	Funeral Director	1 □ Never Married 2 □ Married   1 □ Yes 2 ☒ No	. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, o	Black, White, etc.
21215-0036	ours a	þ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: White
5	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any figury or other traumatic svent, the Medical Examinar must be notilled at anone.	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
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פַ	oths	BeC	17. Father's Name (First, Middle, Last)		Middle, Maiden Sumame)
ylaı	Menta	To	Arthur Barry Perry	Frances Haz	zel Buckley
Maryland	12 sh h and 7 is m traum	1		ling Address (Street and Number or Rural Route	
<u>ق</u>	1 and Healt lem 2		Chontelle Norris / Daughter 9829  20a. Method of Disposition 20b. Place of Disp	Moyer Road Damascus position (Name of Pate Place)	Maryland 20872  20c. Location - City or Town, State
ē	Peges ent of nt: If It		120 Dullar 2 Cremation 3 Premoval from State	Cemetery 1/10/07	Laytonsville, Maryland
Baltimore,	mit. I pertm porter y Inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	
<u> </u>	89558		Theather m. Doff 2	lolesworth-Williams P. <i>A</i> 6401 Ridge Road, Damas	A., Funeral Home scus, Maryland 20872
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respir	atory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		10 Days
	Examiner		Due to (or as a consequence of):		•
	п =	ner	Sequentially list conditions, if any, leading to mine fields.  Due to (or as a consequence of).		
	ecuter end -trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
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89	ifficate g physas the		0.		
Box	th cert lendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy	23d. Date of delivery
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Records,	quires nn sign uld be	ed by	Emphysema		1 2 S 2 No 3 Probably 4 Unknown
000	e law requir has been s ge 2 should	Completed	Obesity	24	a. Was an autopsy findings available prior to completion of cause of
œ =	The cate has pege	Com	Obstructive Sleep Annea	1	performed? death?  Yes 2 0 1 Yes 2 No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death Chec	k only one)
ō	Phys or this oral di	. To	27. Manner of Death 28a. Date of Injury 28b. Time	ant 30 DOX 40 Noting Home 5t	☐ Residence 6 ☐ Other (Specify) scribe how injury occurred
<u>o</u>	nding ath. r: Afte e fune	atior	Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	, ,
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funers! Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		ation (Street and Number or Rural Route Number, y or Town, State)
Ω	pital o		29a Certifier De Certifying Physicians To the best of my knowledge dea	and the second s	
	To the Hospital within 24 hours a To the Funeral I cumpletely filled	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or one)	investigation, in my opinion, death occurred at the	e time, date and place, and due to the cause(s)
	To the	Me	29b. Signature and title of sertifier	29c. License number	29d. Date signed (Month, Day, Year)
	5			D0063196	1/8/07
			30. Name antijaddress of rson who completed caus of death (Item 2 Type	A Print)	MURL MA 201832
	Sta		31. Date filed (Month, Pay, Year) 2007 32 Registrar's Signature	A FITTH LATTE	
	Registr	ar	JMM V J 2007 Janes Dr. A	2016	

			1 - For State Registrar	State of	Marylar		artmen rtificat			ınd M	lental Hygi	ene	07	01632
ŧ	=34	40	Decedent's Name (First, Middle, Last	)			-			1	2. Date of Death	)		3. Time of Death
т	Physici		Robert F. Nesbit	t							January	Day 4, 2	007	1701 PM
	/Medic Examin		4a. Fecility Name (If not institution, give		er)		4b. City,	Town, or	Location o	f Death		T	nty of Deat	
L			Union Hospital					Elk	ton				Ceca	il
2	Funeral Director		5. Social Security Number 6. Se 214-34-3814	x 7. ДМ 2□F	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, NOV. 5,	Year) 1932	1 6	hplace (State or Foreign ountry) aryland
	2		Usual Residence of Decedent											
	how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Ma Ma	Director	Maryland Cec	il	R.	ising S	Sun							1 X Yes 2 □ No
	ih th or 28	Oire	10e. Street and Number				10f. Zip	Code			10	g. Citizen o	of What Co	ountry?
	23a	ral	100 McNamee Lane	, Apt. 3	05			:	21911			USA		
	s des	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13. \	Was Deced	ent of Hi	spanic Orig n, Mexican	gin? (Spe Puerto	cify Yes or No- Rican, etc.)		lace - Ame	ncan Indian, e, etc.
36	or I	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give			1 ☐ Yes	2X No	Specify:			Spec	cify:	11 14
Ö	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show the Model Erstniher mast be motilied at	d b	3 Widowed 4 Divorced	Year or Date	os:	160 Doors	donate I leve	I Ossuss	tion		Ι.	Sh Kind of		Vhite
2	n 72	Completed	15. Decedent's Edi (Specify only highest grad			16a. Deced	kind of wo DO NOT us	k done d	luring most	of worki	ng	6b. Kind of	Business/	industry
12	the.	mc	Elementary/Secondary (0-12)	College (1-4	or 5+)	Farn		,				Fam	ily F	a tim
Maryland 21215-0036	be filed within 72 hours after death with the Marylan Ital Hyglene. d other than "natural", or Items 23s or 28s-1 show event, the Madrell Extending on the notified at		17. Father's Name (First, Middle, Last)			1 WCII			18. Mothe	r's Name	(First, Middle, N			wein
an		To Be	Amos Nesbitt						Mari	u Fr	ancis Pi	0110		
Ž	should ind Men ind marke umartic	-	19a. Informant's Name/Relationship (T	rpe, Print)		19b. Mailin	ng Address	(Street a			Aoute Number		m, State, 2	Zip Code)
Š	4.73 d		Earlene F. Nesbi	tt/wike		100 A	lc.Name	e La	ane.	Apt.	305. Ri	sina	Sun.	MD 21911
ē,	f Head f Head item othe		20a. Method of Disposition	,	20b. I	Place of Dispo								Town, State
Ē	Pages nent of int: If it ury or o		1   Burial 2 □ Cremation 3 □ I  4 □ Donation 5 □ Other (Specify)		EIH I	oewell				1-9-	2007	Port	Denoz	sit, MD
Baltimore,	그 된 원 중	- 1	21. Surfure Funeral Service Licens		1.									
m	Department of the partment of		*Kichard of	Goo	die	11	i 1's.'	-vari	ı runi 2n St	erax ree.t	Home, P , Rising	Sun.	MD 2	1911
			23a. Pert . Enter the disease, or comp shock, or heart failure. List only of	lications that cau	sed the deal									Approximate Interval Between
М	Physician .		Immediate Cause (Final	•							iac synd			Onset and Death
ų.	/Medical		disease or condition resulting in death)	d	as a consec		-5000	-,		COV COL	cuc syria	reome		< 24 hours
	Examiner		Conversion to the search of th	Hypert	ension	$\iota$								>10 years
-		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consec	juence of):								
	cutec nd ransi	Examiner	Cause (Disease or injury that initiated events	c. Pulmon	ary H	yperten	usion							@ 3 years
Ö,	e exe	E	resulting in death) Last	Due to (or	as a consec	uence of):								
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit	dical		d										
9 X	as as	Physician/Med	IF FEMALE:	22- 16										
P.O. Box	w requires that the death cer been signed by the attendin should be detached for use	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	2 Fete	l death 3	Ectopic pr						Date of deli Vonth	ivery Day Year
o.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow		leath 5 L	Other (sp	өсту)						,
	that the	P.	Part II. Other significant conditions co	ntributing to deat	h but not res	ulting in the ur	nderlying c	ausa niva	n in Part I		23e. Did tob	acco use co	ontribute to	the cause of death?
ds,	sign d be	d by	Hypothyroid			<b>y .</b> .	,					s 2 🕱 No		obably 4 Unknown
Ö	requ	etec	Depression											
Division of Vital Records,	The law requires that the tee bas been signed by thoage 2 should be detache	Completed	vepression								24a. Was an autopsy	24t	prior to death?	topsy findings available completion of cause of
a											perform 1 Tes 2		1 ☐ Yes	2 No
<b>=</b>	sicial certii recto	Be	25. Was case referred to medical examiner?	Hospital:		ER/Outpatien		<sub>A</sub> Othe			(Check only one			
ot	Phy r this rai d	: To	1 ☐ Yes 2 💢 No 27. Manner of Death	1 ☐ Inp 28a. Date of I (Month,		28b. Time of		^	4 🗆 1401		ne 5 Resider 28d. Describe ho			city)
on	ding Ib. Afte	tior	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	М	8c. Injury Work 1 □ Y	? ′es 2 ⊡ N			,,		
ISI	I or Attending Physician: after death. Director: After this certific I in by the funeral director.	fica	3 Suicide 6 Could not be	28e. Place of	Injury - At h	ome, farm, str	eet, factory	office	7707050	2	28f. Location (Str.	eet and Nur	mber or Au	ral Route Number,
á	after after I Dire	Certification;	4 Homicide	building	etc. (Specia	y)					City or Town,	State)		
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1X Certifying Phy	sician: To the be	st of my kno	wiedge, death	occurred	at the tim	e, date and	place, a	and due to the ca	use(s) and	manner as	stated.
	n 24 he Fu	edicai	(Check only 2 Medical Exam one)	and manner	s of examina stated.	ition and/or inv	estigation,	in my op	oinion, deat	h occurre	ed at the time, da	te and place	e, and due	to the cause(s)
	To the Hospitel or A within 24 hours after To the Funerel Direc completely filled in by	Σ	29b. Signature and title of certifier	101	٨			License				_		n, Day, Year)
			Jones K.	Weren	br 1	the AVE	1	0044	+5/5		J	anuar	y 5,	2007
	1		30. Name and ad ress of person who c			2.				-6				
	10		Joseph K. Weidne				rlonia	rl Wo	y, R	ising	g Sun, M	D 219	11	
	Sta Registr		31. Date filed (Month, Day, Year)	ALC:	istrar's Signa	ature does	Les .							

			For State	State of	Maryla	nd / Depa	artme	nt of H	lealth a		lental Hy		0007	01633		
			State Registrar	f and		Cei	rtilica	te of L	Death			Reg. Nó.	.007	01000	_	
Н	Physicia	an	Decedent's Name (First, Middle,     TOOTTA								2. Date of De. Month	Day	/ Year	3. Time of Death 5:53 A <sub>M</sub>		
	/Medic	al	JOSHUA	JANUAR  4b. City, Town, or Location of Death				JANUARY	<del>-</del>			_				
	Examin	er	4a. Facility Name (If not institution,	•	oer)		40. City					4c. County of Death				
			HOLY CROSS HO		Age (In vrs	. last birthday)	If Und	SILV. er 1 Year	ER SPRI		8. Date of Birl		MONTGOMERY		_	
	Funeral Director		Months Days Hours Min. (Month, Day, Year)							ACCUI	nplace (State or Foreign Untry) RA, GHANA					
			Usual Residence of Decedent								OUNE 2,	1,00	110001	ui, oimini	-	
	how		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. fnside City Limits		
	e Ma	cto	MARYLAND MONTGOMERY SI					VER SPRING						1 □ Yes 2Ã No	_	
	ith th	Director	10e. Sfreet and Number				10f. Z	ip Code				10g. Cit	izen of What Co	untry?		
	thin 72 hours after death with the Maryland e. "naturel", or liems 23s or 28s-f show Madical Examination notified at		822 HYDE ROAD						20902			,	U.S.A.			
	er de	Funeral	11. Marital Status	12. Was Deced	es?	If Yes, specify Cuban, Mexican, Puerto Ricar					ecify Yes or No Rican, etc.)	-	14. Race - American Indian, Black, White, etc.			
20	hours after turel', or ite	by F	1 Never Married 2 Married 1 Yes 2 M 1 Yes 2 M 1 Yes 6 Never or Dates:			1 ☐ Yes 2 No Specity:							Specify: BLACK			
15-0036	ture		15. Decedent's Education			16a. Decedent's Usual Occupation						16b. Kind of Business/Industry			_	
<u>د</u>	within 72 ene. than *nal	plet	(Specify only highest grade completed)			(Give	kind of w	ork done d use retired	during most	of worki	ng	.00	Tab. Table of Basilloss illustry			
1212	¥ 8 € #	Completed	Elementary/Secondary (0-12)	College (1-2	ior 5+)		FRON	DESK	CLERK			COI	NDOMINIUM	COMPLEX		
	e filed Il Hygi other	Be C	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		_	
<u>a</u>	Aental Aental rked c	To E	HARRISON	OFORI					CON	MFORT	FORT NTORIWAH					
Maryland	should and Men is marke		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maifir	ng Addres	s (Street a	and Numbe	r or Rura	I Route Numbe	er, City o	r Town, State, Z	ip Code)		
	12 a		STELLA OSEI -	SPOUSE					, SILVE		RING, MAR	RYLANI	20902			
o e	es 1 ar of Hee if item or othe		20a. Method of Disposition 1 ☑ Buriaf 2 ☐ Cremation	3 □Removal from S		Place of Dispo cemetery, crea	natory or	ame of other plac	e)		Date	20c. Lo	ocation - City or	Town, State		
Baltimore,	mit. Peges bertment of I sortant: if its injury or o		4 Donation 5 Other (Sp	ecify)		TE OF HE	AVEN	CEMETE	RY	1/27/	2007	SILV	ER SPRING	, MARYLAND		
ğ	permit Depert Import eny in		21. Signature of Funeral Service L	idensee) _	+.				s of Facility I FUNE		OME, INC.					
	40 = 0		Noncy A.	Vaccen	Cre	1	1800	EW HAI	MPSHIRE	E AVE	NUE, SILV	ER SI	PRING, MAR	RYLAND 20904	_	
			23a. Part1. Enfer the disease, or shock, or heart failure. List of	complications that car only one cause on ea	used the dea ch fine.	ith. Do not ent	er the mo	de of dyin	g, such as	cardiac c	or respiratory ai	rrest,		Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Finat disease or condition a. <u>EWINGS SARCOMA</u> resulting in death)									1 YEAR				
	/Medical		Due to (or as a consequence of):													
		2	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										_			
	bed nsit	Examiner														
	be executed icien and burial-transit	xar	that initiated events c.  resulting in death) Last Due to (or as a consequence of):													
/60,	ate be executed nysicien and he burial-transit	cail														
20	ificat g phy as the			1												
XOX	death certificat e ettending phy d for use as th	Z/W	IF FEMALE: 23b. Was decedent pregnant 1								23d. Date of deli-	very				
	deat	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at fime of		Other (s						Month	Day Year		
J.	et the de by the o	Physician/Med	9 Unknown												_	
Ś	law requires thet es been signed b 2 should be deta	by	Part II. Other significant condition	ns contributing to dea	th buf nof re	suffing in the u	nderlying	cause give	en in Part I.					the cause of death?		
Hecord	equit	ted		<del> </del>							101	Yes 2	_No 3 Pro	obably 4 \sum Unknown		
ပို	law les b	ple	24a. Was an autopsy								Sy	24b. Were autopsy findings available prior to completion of cause of				
	sician: The law certificete hes b irector, page 2 s	Completed									perfo 1 ☐ Yes	rmed? 2 🐼 No	death?	2 🗆 No		
VII	Physician: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:				1 0%		of Death	(Check only o	ne)			_	
6	this ald	70	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of		ER/Outpatier			4 🗀 1901	T .			6 □Other (Spec	uty)		
		io I	1 ⊠Natural 5 ☐ Pending	(Month	Day Year)	28b. Time o Injury	28c. Injury af Work?  M 1 \( \text{Yes} \) 28 \( \text{No} \)			28d. Describe how injury occurred						
DIVISION	ten fleat for:	lica	3 ☐ Suicide 6 ☐ Could n	ot be	f Injury - At h	nome, farm, str			.00 2		28f. Location (Street and Number or Rural Route No.			ral Route Number	_	
⋛	after Dire	Certification:	4 ☐ Homicide determi	building	, etc. (Spec	ify)	oot, ladio	, onlo			City or Tov			Tar Hobito Hambor,		
	Hospital or At 24 hours after ce Funerel Directetely filled in by		29a. Certifier 1 X Certifying	Physicien: To the b	est of my kn	owledge, deat	h occurre	d at the tim	ne, date and	d place,	and due to the	cause(s)	and manner as	stated.		
	P Fu	Medical	(Check only 2 Medical E	xaminer: On the bas and manne	is of examin	ation and/or in	vestigatio	n, in my op	oinion, deat	th occurr	ed at the time,	date and	place, and due	to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	4/	7		29	29c. License number 29d.				29d. Dai	d. Date signed (Month, Day, Year)			
1	D		1 Durlen h	dto.	Joen .	ni in		D22	2775			JANU	JARY 4, 20	07		
,			30. Name and address of person v	who completed cause	of death (fte	m 23a) (Type,	Print)					-			_	
			FREDERICK G. BAR	2.07			IN AVE	NUE, S	SUITE 1	L345,	CHEVY CH	ASE,	MARYLAND	20815		
	Sta		31. Date filed (Month, Day, Year)	32 00	gistrar's Sign	the de	ack !									
	Registr	ar	JAN 08	ZUU!	SUR I	C AND	-96									

07-00400 Frederick David O	lar		or Print in Black e of Maryland / De					egible.		
		For State	-	•	e of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1179/0110	Reg. No.	200	7 0 1 6 3
Physiciar Medical Examin	n/ er	Decedent's Name (First, Middle,L Frederick Day	vid Oland I	I			2. Date of D Month January	Death Day 7 14, 2007	Year	3. Time of Death 1103 hrs
	4a. Facility Name (if not institution, give street and number) Holy Cross Hospital					or Location of D ing	eath		County of Death Ontgomery	
Funeral Director	I For							D/YYYY) 9. Biri 1961 <sup>Foreig</sup> Co	thplace (State or In untry)Maryland	
d how any		Usual Residence of Decedent  10a. State								10d. Inside City Limits  1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code 20906							en of What Cour	
er death wi	by Funeral	1. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No.  1f Yes, Give Year or Dates:		3. Was Decedent of If Yes, specify Cub	oan, Mexican, Pu			White, etc.	can Indian, Black, White
36 in 72 hours in han "naturi	Completed b	15. Decedent's Education (Specify Elementary/Secondary (0-12) 1.2	i. Decedent's Education (Specify only highest grade completed)  College (1-4 or 5+)  16a. Decedent's Usual C during most of works.				e retired)	nd of Business/I		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Be Com	7. Father's Name (First, Middle, La			-14-1		lame (First, Midd		10	
AD 215 2 should b h and Ment 27 is marl matic eve		19a. Informant's Name/Relationship (Type, Print)  Toni P. Oland / Wife  19b. Mailing Address (Street and Number or Ru 3522 Harrell Street,						ral Route Number, City or Town, State, Zip Code) Silver Spring, Md. 20906		
more, hages I and ent of Healti		20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other Spec	cremator	Disposition (Name of y or other place) f Heaven (	Date 1/19/07		ocation - City or	Town, State		
Baltin permit. Departm Importa	l	21. Signature of Funeral Service Lic			22 Name and Addr Muriel F P. O. F					20882
Physician /Medical Examiner		23a. Part I. Enter the disease, or co failure. List only one cause on Immediate Cause (Final disease			enter the mode of dyi	ng, such as card				Approximate Interval Between Onset and Death
		or condition resulting in death)  Sequentially list conditions,	Due to (or as a consequence b.	,						
ted linsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence)	<u> </u>					-	
		X UNPENDED	d##23a,2	27 <b>,</b> 28a-f	e, per, ME, g	2863 <b>,</b> 1/25	5/07 TT			
Division of Vital Records, P.O. Box 68760, spital or Attending Physician: The law requires that the death certificate be execut norts after death.  Therefore the this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial—tra	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month  Yes 2 No 9 Unknown								y Day Year
s, P.O. B ires that the d	ह	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vunknown								
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the restile death.  Al Director: After this certificate has been signed by the funeral director, page 2 should be detach.										utopsy findings available completion of cause of es 2 No
Vital ysician:	8	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	✓ EDIO		Other N	ursing Home 5	Residen	ce 6 Othe	
n of Vil	입::	1 V Yes 2 No  27. Manner of Death  1 Natural 5 Pendin	28a. Date of Injury (Month, Day, Year)		me of Injury 28c. I	njury at Work?	28d. Descr	ibe how injur		
Divisior pital or Attend ours after death. icral Director:	ertification:	2 Accident Investig 3 Suicide 6 X Could r	pation 28e. Place of Injury - A	At home, farr	10.20 an	Yes 2X No	28f. Location			ural Route Number, City
Spita cours	اق	4 Homicide determi	ned (Specify) House	2			bilver	Spring,	522 Harre	UL •

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 16, 2007

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Ling Li, MD

111 Penn Street, Baltimore, MD 21201

State 31. Date filed (Month Rey, Year, 8 2007 Registrar

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** Evelyn A. Peterson TANUARY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata Medical lenter Charts -a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2□ Months 4,1923 Kentucky 83 Director 405-18-9353 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Charles Maryland Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2791 Shiloh Church Road 20616 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify Completed by 3 ₩Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I James William Alvey Matilda Daugherty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Morse Daughter Mountain View Rd., Weatogue, Ct. 06089 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Important; If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service Alexandria, Va. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Williams Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allere. List only one cause on each line. Approximate Interval Between Onset and Death Aspiration Preumonia Immediate Cause (Final disease or condition **Physician** day resulting in death) /Medical Due to (or as a consequence of): Obstructive Pulmonary Year s Examiner Sequentially list conditions, i any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-tran Due to (or as a consequence of): Physician/Medical attending pl 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> tly pertension Melittus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed stenosis Cerbral vacular 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 12 No accident 1☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death | Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

certificate be executed Box 68760, Records, P.O. Division or Vital Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Baltimore, Maryland 21215-0036

Registrar

R. Sindhwal

-61614

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) avinel er

Sindhwan's M.D. 11350 Pembruike Squae Suite 304 Woldow, MD 20603

31. Date filed (Month, Day, Year) JAN 09 200

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 5:30 A.M 5, 2007 Alfred John Perrone January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Kingshire Manor Assisted Living Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 11X M 2□ F Yrs. 1912 94 Aug. 28, Director 072-10-1757 Florida Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1X Yes 2 No Directo Virginia Prince William Haymarket 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or olden Examiner πust be United States 15417 Legacy Way 20169-6108 death \ Funeral Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: þ 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Architectural Engineering Hygiene. other than ' Elementary/Secondary (0-12) College (1-4or 5+) Consulting Engineer 4 Professional Engineer other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 Is marked oth Be Antonio Perrone Alfonsina Sabella ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau Alfred J. Perrone, Jr./Son 15417 Legacy Way, Haymarket, Virginia 20169-6108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Queen of Peace Cem. 2007 West Palm Beach, FL. 22. Name and Address of Facility e of Funeral Service License DeVol Funeral Home East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami Spiral Stenosis physician ar s the burial-ti Due to (or as a consequence of): Box 68760 Physician/Medical IF FFMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy perform 1∐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Living Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 ☐ Yes 21 No P this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1X Natural 5 ☐ Pending investigation I Director: A 1 Yes 2 No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e 4.1162 January 5, 2007 مأ

Registrar
DHMH 17 Rev 1/2001

State

19529 Doctors Drive, Germantown, Maryland 20874

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Vinu Ganti, M.D.,

JAN 08 2007

31. Date filed (Month, Day, Year)

		1 - For Amend #5 Per State Registrar	r Fift 6864	<sup>1</sup> 272370	Pen Cei	artmer rtificat	it of H	ealth a Death	and Me	ental Hy	giene 2	007	01637
Dhyoia	ion	1. Decedent's Name (First, Middle, La	*							2. Date of De		Year	3. Time of Death
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Exami	ner	4a. Facility Name (If not institution, giv						Location o	f Death			nty of Death	
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Funeral Director		<del>011</del> -40-0200	1 M 2□F	ge (In yrs. last	Yrs.	Months	Days	Hours	Min.	(Month, Da April	3,1951		place (State or Foreign intry)
land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Te	own or Lo	cation							10d. Inside City Limits
Marylan -f show iled at	ţō	MD Montgom	ery	Nort	h Po	tomac	!						1 ☐ Yes 2X No
r 28a	Director	10e. Street and Number				10f. Zij	Code				10g. Citizen o	of What Cou	intry?
th with	a D	16901 Longdraft	Road				2	0878			United	1 Stat	es
IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exeminer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Year or Dates:	? No		Was Dece If Yes, spe 1 ☐ Yes		spanic Ori n, Mexicar Specify:	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)		lace - Ameri lack, White cify: Wh:	, etc.
21215-0036 d within 72 hours af giene. r than "natural", or the Medical Exami	Completed	15. Decedent's E (Specify only highest gr.	ducation ade completed) College (1-4or			dent's Usu kind of wo DO NOT u		ation luring most )	t of workin	g	16b. Kind of	Business/Ir	ndustry
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G, Mary 1 and 2 shoi Health and N Health and N Health and short straums		19a. Informant's Name/Relationship ( Jane E. Pelkey (						and Numbe			er, City or Tow		
Baltimore, permit. Pages 1 a Department of Hes Important: If Item any injury or othe		20a. Method of Disposition  1 Burial 2 XCremation 3 4 Donation 5 Other (Speci		e		osition (Na matory or itan		*	Jan. 200		20c. Locatio	-	
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'dS, P.O.   uires that the de signed by the a ld be detached f	<u>\$</u>	Part II. Other significant conditions	contributing to death	but not resultin	ng in the u	nderlying	cause give	en in Part I.			tobacco use co Yes 2 □ No		the cause of death?
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Or Vital Physiclan: Tribis certificate	Be	25. Was case referred to medical examiner?	Hospital:						of Death	(Check only	one)		
Ing Phys After this	on: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of In	Date of Injury (Month, Day Year)  28b. Time of Injury Work?  28d. Desc					Residence 6 Other (Specify) ibe how injury occurred				
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Regist			2007	h		Casti	Đ						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Virginia Elizabeth ROWLAND 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 220-42-5539 60 Director Dec. 31,1946 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland 1 ☐ Yes 2KINo Washington Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12258 St. Paul Road 21722 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white Completed by 3 ☐ Widowed 4 🕅 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) shipping clerk electronics 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert L. Burger Elizabeth C. Mills 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun once. Michelle Andrews - daughter 16244 Mt. Tabor Rd., Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 1/13/07 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility MINNICH FUNERAL HOME №415 E. Wilson Blvd., Hagerstown, Maryland 21740 111. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) mumorus /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2又No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28¢. 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, use as signed by has page 2 certificate Physician: director.

should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show

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Baltimore, Maryland 21215-0036

and burial-trai attending physician for use as the buria the After this funeral or Attending 24 hours after death. e Funeral Director: A the filled in by Hospital

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within 2

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Medical

29a. Certifier

29b. Signature and title of certifier

and manner stated

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12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30 0 32. Registrar's Signature

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 10 **Physician** 200-Martha Yocum Rawlings 03. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death **Examiner** Hartord INUnder 1 Year (0) 1+1Zens NUrsing 8. Date of Birth (Month, Day, Y March 5, Birthplace (State or Foreign Country) If Under 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) 911 **Funeral** Hours Min. 1□M 2XF Months 95 Maryland 217-74-4337 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinal must be notified at 1 □XYes 2 □ No Directo Maruland Harkord Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 69 Mount Royal Avenue 21001 <u>USA</u> Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 □ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within all Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Accountant Private School 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be Pierce Yocum Mary Siebold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health item 27 t Grace M. McCannon/sister-in-law 69 Mount Royal Ave., Aberdeen, MD 21001 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of himportent: If ite any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) West Nottingham Cem. 1-8-2007 Colora, Maryland 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, 21. Signature of Funeral Service Licensee MD 21911 ichong 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one. Approximate Interval Between Onset and Death Immediate Cause (Final 0 1/0m+117/ Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-transit Exami Due to (or as a consequence of): Awlings, Martha Y Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent preg 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) 2 \( \text{A} \text{No} \) this certificate has 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home Hospital: 1 Inpatient 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) 2 1 □ Y9⁄s 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Murner of Death Certification; After 1 5 Pendina Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) termined 4 Homicide To the Hospital 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) and title of certifier 29b. Signatur

Registrar
DHMH 17 Rev 1/2001

State

ddress of p

2007

Date filed (Month, Day, Year)

30 Name and a

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Greta L. Ricucci January 4, 2:20 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 M 2 K 578-38-6251 76 March 15, 1930 Washington, DC **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "neturet", or itema 23a or 28a-1 show ury or other traumatic event, the Madical Examinat must be notified at 10d. Inside City Limits Completed by Funeral Director 1 Tyes 2X No Virginia Fauquier Warrenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20186 132 Mosby Circle United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ₩ Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Graham L. Hill Elizabeth Buckler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Jane Plummer/Daughter 13891 Chelmsford Drive, Gainesville, VA 20155 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State January 5, Metropolitan other place) 1 □ Burial 2 X Cremation 3 □ Removal from State permit. Page Department of Important: if ony injury or 4 □ Donation 5 □ Other (Specify) 2007 Crematory Alexandria, Virginia 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home, 10 East once. Deer Park Drive, Gaithersburg, MD 20877 23a. Part. Enjoying disease, or complications that caused the death shock, or hear trailive. List only one cause on each line.

Immediate Curse (Final disease or condition Yo not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death te cere **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 □Unknown Be Completed 1 Yes funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy m 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No Medical Certification: To 1 🗌 Yes 1 Inpatient 3 DOA 2 PER/Outpatient 5 Residence 6 Other (Specify) inis 28a. Date of Injury (Month, Day Year) 27. Manner of Death After ( 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A investigation 2 Accident Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) DO4115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSEL BIRSCHBACH nio JAN 08 31. Date filed (Month. 32 egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

-C&A Box 68760, + C P.0. Records, Division or Vital RANK

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completely filled in by To the Hospitai within 24 hours a To the Funeral I Hospitai

> State Registrar

Atul Rohatgi 31. Date filed (Month, Day, Year)

**JAN 05** 

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

9901 Medical Center Drive, Rockville, MD 20850 egistrar's Signature

1/0061302

29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State of Marylar	-	artment of I rtificate of		Reg.	211111	01642		
Physici	ian	Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death		
/Medi	cal	Richard Newbol			4h City Town	or Location of Death	January	5 2007 4c. County of Dear	2:00 P M		
Examir	ner	Anne Arundel Med				apolis	·	Anne Aru	_		
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign		
Director		217-40-0104	XM 2□F 59	Yrs.	World's Days	TIOUIS IVIIII.	July 6,	1947 Wa	sh., D.C.		
and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits		
Mary February	to	MD Calvert		Owir	nas				1 XYes 2 No		
th the	lrec	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What Co	ountry?		
id K. I.K. 13-0030 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or lieme 23a or 28a-f ehow ont, the Medical Examulation is callified at	Funeral Director	2330 Dunkirk Dri				736		USA			
item de	nue	11. Marital Status 1 ☐ Never Married 27 Married	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 ☐ No	.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit			
urs af	þ	3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give Year or Dates: Viet	nam	1□Yes 2□XNo	Specify:		Specify: W	hite		
72 ho	Completed	15. Decedent's Ed (Specify only highest gra	lucation	16a, Dece	dent's Usual Occu	pation during most of wor	rkina 161	b. Kind of Business	Industry		
within ne.	m Jg	Elementary/Secondary (0-12)	College (1-4or 5+)					Universit	v Svetem		
yiding Alia buld be filed with Mental Hygiene. arked other that	e Co	17. Father's Name (First, Middle, Last)	5+ Executive Direct 17 Father's Name (First Middle Last)					iden Sumame)			
should be fill and Mental Hy marked oth	To Be	Newbold Frank Ro	se			Mary Ca	yton				
2 shou and M is mar		19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Stree	11-2-1	-	City or Town, State, Zip Code)			
2 2 2 5 2		Carla V. Rose / s	-		) Dunkirk		Owings, M				
Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☐ Burial 2 🏹 Cremation 3 ☐	Memoral nom State		osition (Name of matory or other pla			c. Location - City or			
글 글 원 권 중		4 □Donation <sup>2</sup> 5 □ Other (Specify 21. Signature of Funeral Service Licen	Metr Metr		an Crema  2. Name and Addr	A CONTRACTOR OF THE PARTY OF TH	2/2007 A		, VA.		
Depa Depa Impo		21. Signature of Purity Service Electric	00	44-14		rain Hwy.	Beall Fune: Bowie,		715		
		23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused the deal	h. Do not en	ter the mode of dy	ing, such as cardiad			Approximate Interval Between		
Physician		fmmediate Cause (Final disease or condition	one cause on each line.	UNO	Cana	ev			Onset and Death  2 WOS		
/Medical		resulting in death)	Due to (or as a consec		1			·	20010-		
Examiner	L.	Sequentially list conditions,	b	211							
led	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uanea otj:							
be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a consec	uence of):							
e be ex	cal		d								
oo rtificat ng ph) as th	0	IE ECMAIE							-		
Physician: The law requires that the death certificate be executed riths certificate has been signed by the attending physician and rial director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23d. Date of de Month	23d. Date of delivery Month Day Year						
w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause gi	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?		
w requires to been signer should be	leted b						1 Yes	2 No 3 Probably 4 Unknown			
aw re	plet						24a. Was an autopsy		utopsy findings available completion of cause of		
The   The   zate ha	Comple						emorned		_		
VICAL DEC SICIAN: The law s certificate has b lirector, page 2 s	Be (	examiner?						th (Check only one)			
off of Vical ding Physician: th. After this certifical funeral director, p	2	1 Yes 2 No 27. Manner of Death	then: 4 Nursing Hury at ork?	fome 5 Residence		city)					
Afte fune	ton	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	ow injury occurred						
Attending at death.	ertification;	3 Suicide 6 Could not be determined	28e. Pface of Injury - At h	ome, farm, st		Yes 2 No	28f. Location (Stree City or Town, S	et and Number or R	ural Route Number,		
tel or 's afte el Dir	Cert	4   Homode	building, etc. (Speci	· · · · · · · · · · · · · · · · · · ·			City of Town, 3	olate)			
To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, dear ation and/or in	th occurred at the to nvestigation, in my	ime, date and place opinion, death occu	a, and due to the caus urred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)		
To Within	Z	29b. Signature and title of certifier	111100			ise number $19827$		Date signed (Mont			
(19)	3	30. Name a d addre s of person who	completed cause of death /Ite	n 23a) (Tvna	Print)	11000	0 0	1-1200	T		
0-1011			selouicu, u	40	700 B	Rstgall	Ra. Au	nuapoli	s, uld.		
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign								

DHMH 17 Rev 1/2001

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: funeral After Director: within 24 hours a

altimore, Maryland 21215-0036

28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural Accident

5 Pending investigation 6 Could not be determined

Charles

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number

29b. Signature ss of person who completed cause of death (Item 23a) (Type, Print)

J.

3□ Suicide

29a. Certifier

4 Homicide

(Check only one)

58303

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) January 6 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

31. Date filed (Month, Day, Year)

MA

6701 N. Charles ST BATTHOR NO 21204 32. FI gistrar's Signature

WO

EG.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 4

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		Registrar Certificate of Death Reg. No.									
Physicia edical Exami	an/	1 Decedent's Name (First, Middle, Last)  Anne-Marie Reiber				2. Date of De Month January	ath Day Year	3 Time of Death 1341 hrs			
St. was		Facility Name (if not institution, give street and number)     700 S. Stepney Road	4	4b. City, Town, of Aberdeen	or Location of D	eath	4c. County of De	ath			
Funeral		5 Social Security Number 6. Sex 7. Age (In yrs last birth	nday)	If Under 1 Ye	ear If Under 24	4Hrs 8 Date of B		Birthplace (State or			
Director	5	217-88-7274 1 M 2K F 33	Yrs		ys Hours	Min	Fo	eign Country)Maryland			
		Usual Residence of Decedent					127 1373	TALYLANA			
ow any			10c. City, Town or Location  10d. Inside City Limits  Aberdeen  1 Yes 2 X No								
ryland a-f sh	ctor	Maryland Harford Aberdee	n	10f. Zip Code	<u>.</u>	······	10g Citizen of What C				
ith the Maryland 23a or 28a-f show notified at once.	Director	700 South Stepney Road		2100	)1		USA	outhly:			
eath with 1 items 23s	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Married Armed Forces?				(Specify Yes or N		nerican Indian, Black,			
r deatl	Fun	1 Yes 2 X No	-	-		ierto Rican, etc.)	White, etc	White			
urs afte tural"	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates  15. Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 15 Decedent's Education (Specify only highest grade completed) 16a. If Yes, 16a. If Yes		Yes 2 X N	, ,	of work done	Specify 16b. Kind of Busine				
during most of working life. DO NOT use retired)											
003( within itene ner tha	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  15. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  Homemaker  16. Kind of Business/Industry  Own Home  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)										
Baltimore, MD 21215-0036  Deprint Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Field and Montal Hygiene Inpopraties 1 filtem 27 is marked other than "natural", or items 23a or 28a-f she injury or other transmatic event, the Medical Examiner must be notified at once	Be C	17 Father's Name (First, Middle, Last)  John Augustus Reiber			1	lame (First, Middle, Rae Masz					
212 ould b d Ment s mark	To E	19a. Informant's Name/Relationship (Type, Print )	. Mailing	Address (Str	eet and Number	or Rural Route Nu	ımber, City or Town, St	ate, Zip Code)			
Baltimore, MD sernit Pages 1 and 2 sho Department of Health and Important: If item 27 is njury or other transmati	1										
Ore,	1 X Burial 2 Cremation 3 Removal from State crematory or other place)										
Itim		4 Donation 5 Other Specify  Harford Memorial Grdn 1-18-07 Aberdeen, Mary 21. Signature of Funeral Service Licensee									
Ba perm Depa Imp		22 McConnas Funeral Service Licensee 22 McConnas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland									
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	t enter th	ne mode of dyin	g, such as cardi	ac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner		nmediate Cause (Final disease a Methadone intoxication Death									
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	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of).					_	_			
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tal tar	an/Medical	X UNPENDED  X AMENDED  #23a, PIP, 27, 27	8a-18	65, 3/17/ peri£,	07 TT 2864, 2/2	2/07 TT					
68760, ertificate be ding physic e as the bur	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fe	tal death 3	Ectopic pre	egnancy	23d Date of deliver Month	ery Day Year			
Box (e death ce the attended for use	Physicia	1 Yes 2 No 9 ✓ Unknown 9 Unknown	Otl	her (Specify)							
e = e	Phy	Part II. Other significant conditions contributing to death but not resulting	ın the u	inderlying cause	given in Part I	23e. Did	tobacco use contribute	to the cause of death?			
res that the signed by be detach	d by	Cardiomegaly and bronchopneumonia				1 Y	es 2 🗸 No 3 📗 F	robably 4 Unknown			
ords, w requir	olete					24a. Was		autopsy findings available to completion of cause of			
tal Records rian: The law requi certificate has been	Completed					perf	ormed? death 2 No 1	?			
of Vital Records, ag Physician: The law requir wher this certificate has been some all director, page 2 should	Be (	25. Was case referred to medical examiner? Hospital: 1 Innatient 2 ER/O			Other	eck only one)					
of Viring Physical After this	2	1 Yes 2 No	itpatient ime of li		jury at Work?	ursing Home 5	Residence 6 🗸 Ot	her Scene			
ion of tending Pt eath tor: After I the funeral	tion	1 Natural 5 Pending Find 1/1//2007 Find		· ·   <sub>1</sub> _	Yes 2 X No	I					
Division tal or Attendi rs after death al Director:	ifica	2 Accident Investigation   Find 1/14/2007   Find 1:20 pm   Suicide									
Divi	Certification:	4 Homicide determined (Specify) found at res	idenc	ce		Aberdeen	n, MD	stepney koad			
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a Certifier (Check only a Certifying Physician: To the best of my knowledge, dea one) 2 Medical Examiner: On the basis of examination and/or in	th occur	red at the time,	date and place, on, death occurr	and due to the cau	use(s) and manner as s	tated			
To the within To the Complex c	Med	29b Signature and the of pertifier and manner stated			nse number		29d Date signed (				
				0.0	.M.E.		January 15, 20				
		30 Name and ad as sof a rson who completed cause of death (Item 23a)		-			.1				
		Mary G. Ripple MD. Deputy Chief Medical Examiner	111	Penn Stree	et, Baltimore	e, MD 21201					
S Regis	tate trar		K	and?							
DHMH 17 Rev 1/2	2001	JAN 2 3 2007   Steems A	IGINA	L		- · · · · ·					

		1 - State Registrar	•	partment of Health and ertificate of Death	Reg. No	200/ 01040
Physic /Med Exam	ical	Decedent's Name (First, Middle, Last)     Brad Lee Stot     4a. Facility Name (If not institution, give str	ctlemyer eet and number)	4b. City, Town, or Location of Deat	2. Date of Death Month Day January 6 h 4c.	Year 2007 3. Time of Death  10:55PM
Funera Directo		13529 Marsh Pike 5. Social Security Number 6. Sex 101 Usual Residence of Decedent	7. Age (In yrs. last birthd	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 3 196	Washington County  9. Birthplace (State or Foreign Country)  Maryland
15-0036 72 hours after death with the Maryland 7astural; or tiems 23a or 28a-f show sidical Examinar must be notitized at	eral Director	Maryland Washingt  10e. Street and Number  13529 Marsh Pike		agerstown  10f. Zip Code  21742  3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer		10d. Inside City Limits 1 □ Yes X□ No  zen of What Country?
.1215-0036 within 72 hours after of ene. then "natural", or Iter he Medical Exeminer	Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	1   Yes, Give   Year or Dates:	If Yes, specify Cuban, Mexican, Puer  1 ☐ Yes 2 ☒ No Specify:  Indeedent's Usual Occupation  If we kind of work done during most of wo  ive kind of work use retired)	16b. K	Black, White, etc.  Specify: White  Ind of Business/Industry
land 2	To Be Com	12 17. Father's Name (First, Middle, Last)  David Walter Sto	ottlemyer		me <i>(First, Middl</i> e, <i>Maiden</i> tricia May C	lopper
timore, Mary t. Peges 1 end 2 shoul dract of Health and M riant; if item 27 is mari		Patricia M. Stot1  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Rei  4 □ Donation 5 □ Other (Specify)	clemyer - mother 20b. Place of Di cemetery,	13529 Marsh Pike sposition (Name of prematory or other place)	Hagerstown M	
Dalim permit Per Departmen Important;		21. Si nature of Funeral Service Licensee	V. Zury	22. Name and Address of Facility D 1331 Eastern Blvd	ouglas A. Fi . N. Hagerst	ery Funeral Home own Maryland 21742
S / 60,  sale be executed  Wedica Examined  hysician and the burial-transit	Ical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	DO 10 MY OCA	Thy exict	Initerval Between Onset and Death Onset and Death
T.O. BOX 687, the death certificate by the attending phys teched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
ecords, P.O. lew requires that the as been signed by th	þ	Part II. Other significant conditions contr	ibuting to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2	se contribute to the cause of death?
The The page	e Completed	25. Was case referred to medical		20 Please of Do	24a. Was an autopsy performed 2  1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Phys r this aral dir	atlon: To B	examiner?  1 Yes 2 No Ho  27. Manner of Dealn  1 Natural 5 Pending 2 Accident Investigation	spital: 1	tient 3 DOA Other: 4 Nursing F	tome 5 Residence 28d. Describe how injur	
	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, State	
To the Hospital or within 24 hours effe To the Funerel Directions completely filled in	Medical	29a. Certifier Check only and its learning one)  29b. Signature and title of certifier	r: On the basis of my knowled a d r: On the basis of examination and/o and manner stated.	eath occurred at the time, date and laccor investigation, in my opinion, death occurrence and laccordinate a	urred at the time, date and	and manner as stated. I place, and due to the cause(s) e signed (Month, Day, Year)
J W T Q		30. Name and addr /s of person who com	pleted cause of death (Item 23a) (Tv	0002652	3 594	72209
OH -L S Regis	tate trar	DIPD J. DEJ 31. Date filed (Month, Day, Year) JAN 1 0 200	32. Registrar's Signature	Melyal	RASAV)	1902 7174L

			1 - State of Marylan	id / Depa		of Hea	alth and N	Mental Hygi	_	7 01647		
	Physici /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Ann Harrington Sturgis					2. Date of Death Month Jan		3. Time of Death		
4	Examir		4a. Fecility Name (If not institution, give street and number)  Genesis HealthCare — The P	ines		Eas	cation of Death ston		4c. County of	Death Lbot		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. 73)  Usual Residence of Decedent	last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Feb. 22	, 1933	Birthplece (State or Foreign Country) Mary Land		
	Maryland I-f ehow	tor		y, Town or Lo	Salis	bury				10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
B	th with the 23a or 28a	Funeral Directo	10e. Street and Number 112 Lakeview Dr.		10f. Zip (	<sup>218</sup>	802	10	g. Citizen of Wha	. Citizen of What Country? USA		
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "neturel", or itama 23a or 28a-f show or other treumatic event, the Modical Examinar must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decede If Yes, specif 1 Yes 2	/	inic Origin? (Sp Aexican, Puerto Specify:	ecrfy Yes or No- Rican, etc.)		American Indian, White, etc. White		
21215-0036	ed within 72 h giene. er than "netu , the Madical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  2			Schoo	n ng most of work 1 Teach	er		ucation		
yis yland	12 should be filed w h and Mental Hygier 7 is marked other ti freumatic event, Ih	To Be (	17. Father's Name (First, Middle, Last) Emerson C. Harrington, Jr.				Winif	e (First, Middle, M red Davi	S			
ture, Mar	s 1 and 2 sh f Health and ftem 27 is m other freum		19a. Informant's Name/Relationship (Type, Print) Kimberly S. Cohee/Daughter  20a. Method of Disposition 20b. P	4518	Gado	w Rd.	, Prest	al Route Number, on, MD 2	1655			
Ann St. Baltimore,	Pa Int:		1 Surfacture of Funeral Service Licensee		ırchGr	aveya	rđ 1/9/	2007	oc. Location - Cit Cambridg	se, MD		
Ba Ba	Dermit. Departn Imports any inje		23a. Part I. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	LLL 3	Curran 308 Hi	Brom gh St	well Fu	neral Ho	me, P.A. D 21613	Approximate		
	Physician /Medical Examiner		fmmediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence)	ve flex vence of):	est fa	Ture	thy			Interval Between Onset and Death		
68760,	icate be executed physicien and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence	uence of): exists uence of): exists	gene	ali zeo	?			gears		
P.O. Box (	that the death certificat ed by the attending phy deteched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2\to No   9   Unknown   Unknown   23c. ff yes, outcome of pregnant   1   Live birth   2   Fetal   4   Pregnant at time of december   9   Unknown   9   Unknown   1   1   1   1   1   1   1   1   1	I death 3	Ectopic pre				23d. Date of Month	f delivery Day Year		
	w requires that been signed t should be dete	þ	Part If. Dther significant conditions contributing to death but not resu	ufting in the ur	nderlying car	use given in	Part I.			te to the cause of death?  Probably Yunknown		
of Vital Records,	hysicion: The law re his certificate has be il director, page 2 sho	e Completed	25. Was case referred to medical					24a. Was an autopsy perform	24b. Wer prior deat No 1	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \text{No}\)		
C S S S S S S S S S S S S S S S S S S S												
_	To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by th	ledical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my known and manner stated.	wledge, death tion and/or inv	occurred at restigation, in	the time, on my opinion	late and place, on, death occurr	and due to the cau ed at the time, dat	use(s) and manne e and place, and	or as stated. due to the cause(s)		
	To th withir To th	Me	29b. Signature and title of certifier		29c.	License nu	9959	5 29	d. Date signed (M	onth, Day, Year)		
-			30. Name and address of person mo completed cause of death (Item MICHREL ROWLY, MD GIO	3 Du	Print)	ANS	LANG	EAS	STON, M	ND 21601		
Ü	Sta Registr	_	31. Date filed (Month, Day, Year)  JAN 0 8 2007  Clause	ture	Sport							

			1 _ For State	State of Marylan	id / Dep		lealth and	Mental Hyg	iene (	07	01648
		27	Registrar  1. Decedent's Name (First, Middle, La	st)	- 00	rancate or	Death	2. Date of Deat	eg. No.		3. Time of Death
	Physici	an	John D. Spen					Month	Day	Year	
	/Medic		4a. Facility Name (If not institution, giv			4b. City. Town. o	or Location of Deat	<u>January</u>	9, 20	UU/ y of Death	12:40 AM
	Examir	ier	Calvert Manor He		r		ng Sun			cil	
	Funeral	F	5. Social Security Number 6. S	iex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs				place (State or Foreign ntry)
12.	Director		236-18-2483	2M 2□ F 86	Yrs.	Months Days	Hours Min.	June 25			oniny) ginia
	D .		Usual Residence of Decedent								
	show		10a. State 10b. County	10c. Ci	ty, Town or L	ocation					10d. Inside City Limits
	Be-f	cto	Maryland Cecil	No	rth Ea	st					1 X Yes 2 □ No
	و ع و 2	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
	23a	Ta .	902 Elk River M	anor		21901			United		
	ement and a	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)		ce - Amen ack, White,	
36	s afte	Ž.	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 📉 No	Specify:		Speci	ity: W	hite
21215-0036	be filed within 72 hours after deeth with the Maryland ital Hygiene. id other than "natural", or items 23a or 28e-f show event, Ite Mackel Estruiter must be callified a	Completed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's E	Year or Dates:	162 Dece	dent's Usual Occur	nation		16b. Kind of I		
<u> </u>		lete	(Specify only highest gra	ade completed)	(Give	kind of work done  DO NOT use retire	during most of wo	rking	100, Kind of I	202111622711	idustry
12	within then.	Ë	Elementary/Secondary (0-12)	College (1-4or 5+)		aurant Ov			Dogto		**
	filed Hygid Sther ent,	Ö	17. Father's Name (First, Middle, Last	)	Rest	aurant ov		me (First, Middle, i		auran me)	L
Maryland	d be ental	To B	George Hilton	Spence			Martha	Lee Cai	n		
<u></u>	2 should be filed within and Mental Hygiene. is marked other then eumatic event, the Me	F	19a. Informant's Name/Relationship (		19b. Maili	ng Address (Street				n, State, Zij	o Code)
<b>S</b>	end 2:		Jack Spence / Br	other							rolina 2712
ଦ୍	一工五五		20a. Method of Disposition	20b. F		osition (Name of matory or other pla		Date	20c. Location		
Baltimore,	Pages nent of int: if it		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speed	Triginoval nom State		e <b>Cre</b> mato	, -	uary 2007 1	Torzo 11	Do 1	
1	permit. Pages Department of Important: if it any injury or o		21. Signature of Juneral Service Lice			2. Name and Addre	an of Capille.	_	Newark,		aware
B	permit. Depart Import any inj		140 H- 4				C	rouch Fu			ryland 2190
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a. Congestions  Due to (or as a consecution)  Due to (or as a consecution)	th. Do not en		ng, such as cardia	c or respiratory arr			Approximate Interval Between Onset and Death Mowth
68760,	icate be executed physicien and s the burial-trensit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
O. Box	The law requires that the death certificate sie has been signed by the ettending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3[		у			ate of deliv	ery Day Year
<u>α</u>	s that ned b	by Pi	Part II. Other significant conditions	contributing to death but not res	sulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	bacco use cor	ntribute to t	he cause of death?
g	aure n sig	d b						1 🗆 Y	es 2 No	3 🗌 Prol	bably 4 Unknown
Records,		Completed						24a. Was a autops perform	n 24b sy med? 2 PANo	Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available impletion of cause of
Vital	cian: ertific	Be	25. Was case referred to medical examiner?					ath Check only on	10)		
Ę	Physician: r this certific ral director,	မှ	1 Yes 2 No		ER/Outpatie	III 3 DOA	her: 4 Nursing I	dome 5 ☐ Reside	ence 6 🗆 Ot	her (Speci	fy)
n	fter t		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	ry at rk?	28d. Describe ho	ow injury occu	irred	
sio	eath.	cat	2 Accident investigation 3 Suicide 6 Could not t	1		M 1	Yes 2 No				
Division of	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Certification:	4 Homicide determined	building, etc. (Speci	fy)			City or Town	n, State)		al Route Number,
	ne Hospi 24 hou ne Funei bietely fil	Medical	29a. Certifier 1  Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, dea ation and/or in	th occurred at the to nvestigation, in my	me, date and place opinion, death occ	e, and due to the curred at the time, d	ause(s) and n ate and place	nanner as s , and due t	stated. to the cause(s)
	To the within To the Comp	Z	29b. Signature and title of certifier	0		29c. Licen	se number	2	9d. Date sign	ed (Month,	Dey, Year)
)			1 1/0/0 5	hat		D 00	258354		11910	7	
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	, Print)	- 000		1113	1,	
1	1		DEIL E. LATTIN MI	101 COLONIAL	- Way	, Risina	Sun , r	ND 210	111		
13	St		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1	) , , ,				-
	Regist	rar	ΙΔΝ 1 0	2007 Magaza	S.	40340					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend PII, 25, 27, 28a-f, per ME, g867, Sentificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** yron Stov 8:35 A M 5R W. 2007 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Poolesville 19700 Bodmer Avenue Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 577-10-9796 86 Director Sept. 30 1920 Tennessee Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location rthan "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits 1 XYes 2 No Md. Montgomery Poolesville Direct 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? United States 17631 Kohlhoss Road 20837 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify <u>ک</u> Specify White 3 Nidowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Contractor Carpentry 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental H McClary Sandy Story Vetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 to Department of Health ar Important: If Item 27 leany injury or other trausons. . 18924 Liberty Mill Road, Germantown, Md. 20874 Mark Sean Story / Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 1/8/07 4 ☐ Donation 5 ☐ Other (Specify) Germantown, Md. Germantown Baptist 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Box 5038, Laytonsville, Md. P. O. 23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NED BY MEDICAL EXAMINER Due to (or as a consequence of) Examiner physicien and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: USB USB 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ĕ Day Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š SEPSIS, Hip fracture with complications 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No paga certificate 1 Yes director, 25. Was case referred to medical Be 28. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Grandlaughter Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ္င 1 X Yes -2K this funeral 27. Manner of Death After t Certification; 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Alvatoral** 5 Pending death. 2 Accident investigation Oct. 9, 2006 10:30 pm M 1 ☐ Yes 2 🕅 No subject fell Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide aftar Assisted Living Facility within 24 hours a To the Funeral D 990 Waterford Dr. Frederick, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0060417 January 3, 2007 +1 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Hemen P. Shah, M.D.

JAN 08

2007

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

egistrar's Signature

65C Thomas Johnson Drive, Frederick, Md.

1 - For State Registrar

			1 - State Registrar	Cer	tificate of D	Death		Reg. No	2007	016	51
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Maria Alter Shima				2. Date of Do Month Januar	eath ry .	3, 2 <sup>Year</sup> 7	3. Time of 2:15	Death a M
)	Examin		4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL		4b. City, Town, or L		th		. County of Death		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last.	birthdav)		HESDA If Under 24 Hrs	8. Date of Bi	rth	Q Right	TGOMEF lace (State o	
r	Director		217-21-1749 1 M 2 XF 80	Yrs.	Months Days	Hours Min		ay, Year)	Coun	try)	rroreign
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City. To	City, Town or Location 10d. Inside City Limits							
	// Aaryla f shov ed at	ō	MARYLAND MONTGOMERY	WIT OF LOC	ROCKV	TIJE			1	0d. Inside Cit 1 <b>X</b> Yes	•
	the 28a-	Director	10e. Street and Number		10f. Zip Code			10a, Cit	tizen of What Coun		
	h with	a D	6105 MONTROSE ROAD		,	20852		-3-	USA	,.	
	r deal	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of His Yes, specify Cuban	panic Origin? (	Specify Yes or Norto Rican, etc.)	0-	14. Race - Americ Black, White,		
21215-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		☐ Yes 2⊠ No	Specify:		Specify: WHITE			
15-(	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)							ind of Business/Inc	lustry		
D 単名									ELECTR	ONTCS	
										ONICS	
ylaı	ould b Ment arked	10					ODZINSK <i>I</i>				
Maryland	12sh shand 7ism traum				g Address (Street ar.						
	Healt Healt tem 2		20a. Method of Disposition 20b. Place	of Dispos	MCCORMICK sition (Name of		Date		ARYLAND ocation - City or To	20850	)
altimore,	Pages lent of nt: If I ry or				natory or other place, MORIAL GD:		5/2007		EY, MARYL	,	
alti	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Licensee	22.	Name and Address	of Facility					
<u>-</u>	80 E # 9		CHO CO	1109	WARD SAGE 91 ROCKVI	LLE PIK	E. ROCKV	/TLLF	N, INC. E. MARYLA	ND 20	852
Ç.			Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	r the mode of dying,	, such as cardia	c or respiratory a	arrest,		Approximate Interval Bety Onset and D	veen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. PNEUMONIA							2 DAY	
	Examiner		Due to (or as a consequence	e oi).							
	р # <u></u>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease (Disease on Injury)	e of):							
	xecute and I-trans	Examiner	that initiated events resulting in death) Last c	e off:							
68760,	certificate be executed iding physician and ise as the burial-transit		220 to (0) 20 2 001100000010	0 01).							
	rtificat ng phy as the	/Medical									
Вох			IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □Live birth 2 □ Fetal dea	ath 3 🗆 8	Ectopic pregnancy			1	23d. Date of delive		
P.O.	the de	Physiciar	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant at time of death	5 🗌	Other (specify)				Month	Day Y	ear
	res that the death igned by the atten be detached for u	by Ph	Part II. Other significant conditions contributing to death but not resulting				23e. Did 1	tobacco t	use contribute to th	e cause of de	eath?
Vital Records,	The law requires that the death the has been signed by the atter rage 2 should be detached for u	ed b	CORONARY ARTERY DISEASE, UTI, ACU	TE RI	ENAL FAILU	URE	10	Yes 🏖	□ No 3 □ Prob	ably 4 □U	nknown
ဗင္ပ	has be	Completed	HYPERGLYCEMIA, HYPERNATREMIA				24a. Was		24b. Were autor	sy findings a	vailable
E E	ysician: The is certificate hadirector, page	5					perfo	ormed? 2 No	death?		use or
Ĭ.	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  1		Otto		ath (Check only o				
ō	iding Phys h. After this funeral di	٤	27. Manner of Death 28a. Date of Injury 28b	Outpatient  o. Time of	2 DOX	4 LI Nursing I	Home 5 ☐ Resi 28d. Describe		6 ☐Other (Specify	)	
<u>0</u>	ath. rr: Afte	ation	1 🖾 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	28c. Injury a Work? M 1 TY	es 2 □ No			, 00001100		
Division or	al or Attendate date death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f. Location ( City or To	Street an wn, State	nd Number or Rural	Route Numb	er,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; p	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowled 2 Medical Examiner; On the basis of examination and manner stated.	ge, death	occurred at the time estigation, in my opi	e, date and plac nion, death occ	I e, and due to the urred at the time,	cause(s)	) and manner as sta d place, and due to	ated. the cause(s)	
	vithin To th compl	Me	29b. Signature and title of certifier		29c. License r	number		29d. Da	te signed (Month, L	Day, Year)	
)	3		MD MD		DO	0060117			JANUARY 3	3, 200	7
			30. Name and address of person who completed cause of death (Item 23a		rint)						
	Sta	te	ERIC J. PARK, MD 9901 MEDICAL CE  31. Date filed (Month, Day, Year)  32 Registrar's Signature			OCKVILLI	E, MARYL	AND	20850		
	Registr		JAN 0 8 2007 Bleen &	Con	les .						
DHI	MH 17 Rev 1/20	001			· · · · · · · · · · · · · · · · · · ·						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			Please	Type or Pri					-		Legible.	
		For State Registrar		State of M	aryland	-	artment of I r <i>tificate of</i>	Health and I Death	Mental Hy	giene Reg. No.	200-	1 01652
Physic	cian	1. Decedent's Name		ast)					2. Date of De		Year	3. Time of Death
/Med	lical	Micha		Peter  ive street and number)	Senkı	us	4h City Town	or Location of Deatl	JANI	JARY	5, 200	
Exam	iner	Saint	Joseph	n Medical	Cent	ter	4b. City, Town, t	Tow		40.	County of Dea	m ltimore
Funera Directo		5. Social Security N 236-90-	9249	Sex 7. Ag 1 Mg M 2 □ F	ge (In yrs. las 50	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May &	ay, Year)		thplace (State or Foreign ountry) airmont, W.V
/land ow at		Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	cation	-		-		10d. Inside City Limits
e Man Ba-f sh	ctor	MD	Balti	more	Т	'owso	n					1 □ Yes 2 No
ath with th 23a or 20 ust be no	Funeral Director	10e. Street and Nur 305 Eas		a Road Ap			10f. Zip Code 212				zen of What Co USA	ountry?
Datumore, Infally failed A 1.4.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at mone.	þ	11. Marital Status 1 ∰Never Marri 3 □ Widowed	ied 2☐ Married 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	,		Was Decedent of I If Yes, specify Cub 1 □ Yes 2 X No	Hispanic Origin? (S ean, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	)-	14. Race - Ame Black, Whit Specify: V	
72 ho "natur dical I	eted	(Spec	15. Decedent's E cify only highest g	Education rade completed)		16a. Dece	dent's Usual Occu kind of work done	pation during most of world)	rking	16b. Kir	nd of Business	/Industry
within in than the Me	Completed	Elementary/Seco	ndary (0-12)	College (1-4or !	5+)		Sales				Automo	otive
Id be filed fental Hyg rked other tic event,	To Be C	17. Father's Name (	(First, Middle, Las Senkus	st)			· · ·	18. Mother's Nar	ne (First, Middle e Belca			
and 2 shot alth and N 27 Is maler trauma		19a. Informant's Na Jennie		(Type. Print) /Mother		19b. Mailir	ng Address (Street	erlain	arai Route Numb Ave . nue	er, City o	rTown, State, . irmont	Zip Code) C , W . V . 26554
Deficiency of the months of He mportant: If Item any injury or other pages in the months of the mont				□Removal from State	cen	netery, crei	sition (Name of matory or other pla Cremato	ry 1/10	Date / 0 7		cation - City or ganto	Town, State
Dalli permit. Departr Importa any inju		21. Signature of Fu	uneral Service Lice	melle.		Î 9	Name and Addr hilip I 241 Col	Rinald umbia E	li fune Slvd.Si	ral lver	Servi Spri	ce,P.A. ng,Md20910
	м.	23a. Part1. Enter the shock, or hea Immediate Cause (	in tailure. List oni	mplications that caused y one cause on each li	ne.				or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)		a. HEPAT  Due to (or as			IALOPATI	·Υ				DAYS
Examine		Sequentially list col	nditions,	D			L DISEA	ASE				YEARS
uted d ansit	Examiner	Sequentially list col if any, leading to im- cause. Enter Unde Cause (Disease or that initiated events	nmediate erlying injury	Due to (or as	a conseque	ence or):						
be executed sician and burial-transit		resulting in death) L	ast	Due to (or as	a conseque	ence of):						
oo/ fiicate b physic s the b	dica		•	d		-						
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial properties in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal d	déath 3 🛭	⊒Ectopic pregnand □ Other <i>(specify)</i> _	у		2	3d. Date of de Month	livery Day Year
w requires that the been signed by should be detact	by	Part II. Other signif	ficant conditions	contributing to death b	out not result	ing in the u	nderlying cause gi	ven in Part I.		tobacco u		the cause of death?
The law red ate has bee	Completed								24a. Was auto perfe 1  Yes			utopsy findings available completion of cause of
VILCI Ician: Certifical ector, p	Be C	25. Was case refer examiner?		Hoopitel				26. Place of Dea			10168	21010
Phys or this eral dir	1: To	1 ☐ Yes 2 ☐ 27. Manner of Deat		Hospital: 1 Inpatie	ury 2	R/Outpatier 28b. Time o	IL 3 DOA		lome 5 ☐ Resi			ecify)
ending ath. or: Afte	ation	1 Natural 2  Accident	5 Pending investigation		y Year)	Injury	1	rk? ]Yes 2∐No			, 50041104	
tal or Att rs after de al Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	∠ 1 28e. Place of Inj	ury - At hom tc. <i>(Specify)</i>	ne, farm, str	eet, factory, office		28f. Location ( City or To	Street and wn, State)	d Number or R	ural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	OHE	2 // Medical Exa	Physician: To the best aminer: On the basis of and manner st	of examination	iedge, deat on and/or in	vestigation, in my	opinion, death occu	e, and due to the urred at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)
3	)   =	29b. Signature and	title of certifier	my			29c. Licens	i886		Ja.	e signed (Moni	- 2007
			ress of person who	o completed cause of c		, , , , ,	,	THE POLYTER A	halos me er	PR 1		
	tate	31. Date filed (Mon	th, Day, Year)	32 Angiett	rario Signatu	Iro		TOWSON,	MARYL	HMD_	21204	
Regis		J	AN 082	TOUR TOUR	an s Signatu	19	WEL)					

			For State Registrar	State of M	aryland / D		t of H	ealth and			2007	0	1653
	Physici /Medio		1. Decedent's Name (First, Middle,  Jose Roge		eyes	Santia	go		2. Date of D Month JANU	eath Day			me of Death
0	Examir	_	4a. Facility Name (If not institution, Saint Josep		Center		Town, or	Location of Dea		4c.	County of Deat	h time	ore
	Funeral Director		5. Social Security Number 6		je (In yrs. last birti		1 Year Days	If Under 24 Hrs Hours Min		lay, Year)	9. Birt		tate or Foreign
	/land ow at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location	·					10d. Insi	de City Limits
	he Mar 8a-f sh otified	ector	MD Balt:	imore	Сос	keysvi							Yes 2x No
	h with t	al Dir	10e. Street and Number 6 Breeze Hil	ll Court	Apt.F	10f. Zip	2103	0		-	zen of What Co Iexico	untry?	
920	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1X Yes		spanic Origin? ( n, Mexican, Pue Specify: Me	Specify Yes or N rto Rican, etc.) xican	lo-	14. Race - American Indian, Black, White, etc.  Specify: White		
15-0	n 72 ho n "natur n dicai	Completed	15. Decedent's (Specify only highest	grade completed)		Decedent's Usu (Give kind of wo life. DO NOT u	al Occupa rk done d se retired)	tion uring most of wo	orking	16b. Ki	nd of Business/	industry	
212	ed withi ygiene. ier thar t, the N	Comp	Elementary/Secondary (0-12) 1 2	College (1-4or		Landsc	ape				ndscap	e Co	٥.
land	ld be fill ental H ked ott ic even	To Be	17. Father's Name (First, Middle, La Rogelio Reyes						me (First, Middl dia Sa		,		
Mary	nd 2 shou alth and M 27 is mar r traumat		19a. Informant's Name/Relationshi			Mailing Address			Rural Route Num		or Town, State, 2		
Baltimore, Maryland 21215-0036	Pages 1 a nent of Hes int: If Item iry or othe		20a. Method of Disposition  1 the Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control Cont	B Re¶oval from State	20b. Place of cemeter San	Disposition (Na y crematory or Pedro lula, O	me of other place	1/1	Date 3/2007	1	ocation - City or		
Balt	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service Li	censee		PHILI	P Addres	RINALD	I FUNE	RAL	SERVIC	E,P	.A.
1			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that cause	d the death. Do n				Slvd.Si ac or respiratory		Sprii	Approx	ximate al Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	а	C DISSE								HOURS
	Examiner		Sequentially list conditions	. COAGU	LOPATHY	Y						24	HOURS
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of							27	HOURS
رہ) 760,	oe exection and cian and		that initiated events resulting in death) Last	Due to (or as	a consequence of	of):	יוויייי						
§/ 89	ifficate by g physicas the b	edical		d. ISCHE	MIC BRA	-111/ 114	URY					LL 4	HOURS
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	quires that the de in signed by the a uld be detached t	by	Part II. Other significant condition	s contributing to death t	out not resulting in	the underlying	ause give	en in Part I.			use contribute to ☐ No 3 ☐ Pr		e of death?
Bob(F∓) ₩ F. Vital Records,	Physician: The law requires this certificate has been sign al director, page 2 should be	Completed							24a. Wa aut per 1□ Yes	opsy formed?	24b. Were au prior to death?	utopsy find completion	dings available n of cause of
_	ysician s certifi director	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Unpati	ent 2 ☐ ER/Out	tpatient 3 □ D	OA Othe		eath <i>(Check only</i> Home 5 Re		6 ∏Other (See	oifu)	
Sion or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it	I	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of Inj (Month, Da	ury 28b. T		28c. Injury Work		28d. Describe			sity)	
3A(D)OK P	tal or Atters after deal al Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of in	jury - At home, far tc. (Specify)	rm, street, factor	y, office		28f. Location City or T	(Street an own, State	nd Number or Ru e)	ıral Route	Number,
Berz	Hospi 24 hour Funer etely fill	Medical	29a. Certifier 1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis of and manners	of examination and	e, death occurred d/or investigation	at the tim	ne, date and plac pinion, death oc	ce, and due to the curred at the time	ne cause(s e, date an	) and manner as d place, and due	stated. to the ca	use(s)
20	To the within 2 To the complet	Me	29b. Signature and title of certifier			29	c. License	number		29d. Da	te signed (Mont	h, Day, Ye	ear)
	4		30. Name and odress of person w	M.D.	death (Item 22a) /	Type Print	D 3	8570		11.	3/07		
_	17/15		JEFFREY E. S	ELL M.D.	7601	OSLER	DRI	VE TOW	SON, M	ARYL	AND 21	204	
	St Regist	ate rar	JAN 0 8 2	007 Regist	rár's Signature	Couls .							

DHMH 17 Rev 1/2001

			1_ For State	State of Ma	aryland / Dep		lealth and			01654
			Registrar  1. Decedent's Name (First, Middle, L	ast)	06	rincate or	Dealli	2. Date of De	Reg. No.	3. Time of Death
	Physic		MYR	TLE ESTHE	R SROLE			Month JAN.	Day Year 2007	
	/Medi Exami		4a. Facility Name (If not institution, g		IK BROHL	4b. City, Town, o	r Location of Dea		4c. County of Dea	10:50 P M
			HOLY CROSS	HOSPITAL		SILVE	R SPRING		MONTGOME	
	Funeral		Social Security Number     6.		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir		thplace (State or Foreign buntry)
	Director		119-03-7340	1□ M 2[XF	91 Yrs.		110013	JULY 2	1, 1915 NI	EW YORK
	land		Usual Residence of Decedent 10a. State 10b. County	Ap	10c. City, Town or Lo	ocation				10d. tnside City Limits
	Mary f sh	5	MD. MONTGO	MEDV			ODDING			11√2 Yes 2 □ No
	72 hours after deeth with the Maryland naturel', or Hama 23a or 28a-f show alcal Examinat must be notified at	Funeral Director	10e. Street and Number	MEKI		SILVER	SPRING		10g. Citizen of What Co	21
	h with	0	1131 UNIVERS	TTY BLVD. W	VD. W.,#1816 20902				U.S.A.	ond y:
	deeti	ner	11. Maritat Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (S	Specify Yes or No	- 14. Race - Ame	nican Indian,
9	after or its	显	1 ☐ Never Married 21 Married	Armed Forces?  d 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cuban, Mexican, Puerto Rican,		to Rican, etc.)	Btack, Whit	e, etc.
80	urai',	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 🕅 No	Specify:		Specify: WH	ITE
5		Completed by	15. Decedent's E (Specify only highest g	Education rade completed)	(Give	dent's Usual Occup- kind of work done of	during most of wo	rking	16b. Kind of Business/	Industry
12	within ene. than	E	Elementary/Secondary (0-12)	College (1-4or 5-	h)	DO NOT use retired				
9	I the H		17. Father's Name (First, Middle, Las	t)		HOMEMAI		me (First Middle	HOME  Maiden Sumame)	
an	\$ 5 5 F	To Be	LOIS	ZEIENTZ						
Maryland 21215-0036	2 should and Men is marks aumatic	-	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street a		JANET ural Route Numbe	HERSTEIN er, City or Town, State, 2	
	of Haalth a litem 27 is		SAUL SROLE/HUS	SBAND	ŀ				6, SILVER S	2000
ore			20a. Method of Disposition	70	20b. Place of Dispo	sition (Name of natory or other place		Date	20c. Location - City or	
Ĕ	Pages nent of ant: if it ury or o		1 ☐ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation As ☐ Other (Spec	□Hemovat from State ify)		S CREMATO	1	-2007	RIVERDALE	MD
Baltimore,	permit. Page Department ( Important: If any injury or		21. Signature of Funeral Service Lice	nsee /					CREMATORIUM	ъ .
ш	205 29		23a. Part1. Enter the disease, or construction of heart failure. List con-	moura	11000071	DOOT CPE/	LLLAND A	VE. RIV	ERDALE, MD.	,P.A. 20737
760,	Physician / Medical Examiner physicien and buriel-transit the priciel-transit	cal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ATRIAL Due to (or as a Due to (or a) Du	IVE HEART consequence of): FIBRILLATI consequence of): ROIDISM consequence of):					
P.O. Box 68	it tha death certif by the attending teched for use es	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetat death 3 me of death 5	Ectopic pregnancy Other (specify)			23d. Date of deli- Month	very Day Year
	res the igned be de	þ	Part II. Other significant conditions	contributing to death but	not resulting in the un	iderlying cause give	n in Part I.	23e. Did to	bacco use contribute to	the cause of death?
9	w requires been signe should be	eted						1 🗆 Y	′es 2 No 3 Pro	babiy 4 Unknown
Vital Records,		e Completed	25. Was case referred to medical					24a. Was autop perfor 1 Yes	med? death?	opsy findings available ompletion of cause of 2 No
	Physician: r this certifice ral director, I	To B	examiner?	Hospital:	2 ER/Outpatient	20 DOA Othe	_	th (Check only or		
Division of	Attending Phy r death. actor: After thi by the funeral o		27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day)	28b. Time of	28c. Injury Work	at ?		ence 6 Other (Spec. ow injury occurred	fy)
Divis	s aftar deas s aftar dea ni Diractor ed in by the	Certification:	3 Suicide 6 Could not be determined	e 28e. Ptace of Injury building, etc.	y - At home, farm, stre (Specify)				al Route Number,	
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medicai	29a. Certifier (Check only one) TV Certifying Ph	nysician: To the best of niner: On the basis of e and manner state	xammation and/or inv	occurred at the time estigation, in my opi	e, date and place, inion, death occur	and due to the orred at the time, o	ause(s) and manner as state and place, and due	stated. to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			29c. License	number	- 2	29d. Datersigned (Month,	Day, Year)
'	/		1 Kaps	1 1	US.	06	4189		1/3/07	τ
	<i>د</i>		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type, F		, ,			
			RAMA KAPOOR,	M.D. 15	00 FOREST	GLEN RD.	, SILVER	SPRING,	MD. 20910	
	Sta Registra		JAN 0 5 20	07 Soleve	s Signature	de)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Joseph Mousa Saah January 2007 3, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 € M 2 □ F Yrs. 579-68-2495 78 April 19, 1928 Palestine Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6502 Democracy Blvd. 20817 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 25 No Specify: SpecifWhite 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mousa Issa Saah Sara Saah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne J. Saah/ Daughter 6502 Democracy Blvd., Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State January 6, Gate of Heaven Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service License Francis Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death shock

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

₹238 €

5

"natural"

other

pormit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 2008.

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

Director

by Funeral

Completed

Be

Sequentiall if any, lead cause. Ent Cause (Dis that initiate resulting in Examiner Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 25. Was case reterred to medical examiner? Certification: To Be 27. Manner of Death 1 Natural 2 Accident 3 Suicide

23a. Part1. Enter the diseas shock, or heart failure.	e, or compli
Immediate Cause (Final disease or condition resulting in death)	r
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>{</b>

-a. TNEUMONIA	
Due to (or as a consequence of):	
b. EHPHY SEM A  Due to (or as a consequence of):	7
c. RENAL FAI	7

DIABETES HELLITUS

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

4☐Pregnant at time of death

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

3 Probably 4 □Unknown

Aways

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Dames, edele

4 Homicide

29a. Certifier

29c. License number 0062999

29d. Date signed (Month, Day, Year) January, 03, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Petek Donmez, M.D 11119 Rockville Pike, #401, Rockville, MD 20852

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 0 5 2007



To the Funeral Director: After this certific completely filled in by the funeral director,

To the Hospital or Attanding

hours after within 24 hours a To the Funeral C

-00159	.1	Please Type or Print in Black Indelible Ink. Ensure All C	•	_egible.					
ora Mae Snow		otate of Maryland / Bepartment of Fleatin and Men	tal Hygiene	475 475 475	ر مدد مر و ردر ودد				
		Registrar Certificate of Death		Reg No.	1 0 1656				
Physicia ledical Exami: درج		FLORA MAE SNOWBEN	2. Date of I Month Januar	Death Day Year y 6, 2007	3 Time of Death 1443 hrs				
The state of the s		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location Carroll Hospital Center Westminster	of Death	4c. County of Deat Carroll	h				
Funeral					rthplace (State or				
Director	ļ	215-42-7701 1 M 2/F 63 Yrs Months Days Hours	Min Sept	r. 21, 1943 Forei	gn puntry) PA,				
any		10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits				
*	٦	Md. FREDERICK MT. AIRY			1 Yes 2 No				
Maryland 28a-f show 1 at once.	Director	10e Street and Number		10g Citizen of What Cou	intry?				
death with the Maryland or items 23a or 28a-f sh must be notified at once			-0.4.C 1. M	U.S.A.					
eath w	Funeral	1 Never Married 2 Married Armed Forces?		White, etc.	rican Indian, Black,				
after de	by F.	3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No specify.		Specify: BL	ACK				
hours after natural", c		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give during most of working life. DO NOT		16b. Kind of Business.	Industry				
)36 hin 72 e. than "	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  Physical Theval	2151	1+OSPIT.	41				
5-0036 iled within 72 Hygiene. 1 other than	E S	17. Father's Name (First, Middle, Last)  18 Mother		die, Maiden Surname)					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than revent, the Medica	& KERSEY A. JONES ROSA LEE KNIGHT								
and sho	٩	19a. Informant's Name/Relationship (Type, Print) (BRO) 19b. Mailing Address (Street and Nur KERSEY A - JONES, JR 2103 Point Cond	nber or Rural Route	Number, City or Town, State	e, Zip Code 21018				
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City o					
Baltimore, Permit. Pages 1 and Department of Healt Important: If item njury or other tran		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	TAN. 17,	2007 SAMASS	us mb.				
Balti permit. Departm Importa		21 Signature of Funeral Service Licensee 22. Name and Address of Facilit	GARY L.	ROWINS R.	NORR Home				
	_	23a. Part I. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as of	ST PRE	OBRICK MO	31701				
Physician // /Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries	cardiac or respiratory	y arrest, snock, or neart	Approximate Interval Between Onset and Death				
		or condition resulting in death)  Due to (or as a consequence of):  b.							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		· · · · · · · · · · · · · · · · · · ·					
secuted n and transit	Examiner								
ज वं ७	dical	UNPENDED AMENDED							
Box 68760, edeath certificate be the attending physici d for use as the buri	sician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopi		23d Date of deliver	,				
cath certific eath certific attending p	iciar	past 12 months?  1 Live birth 2 Fetal death 3 Ectopi	c pregnancy	Month	Day Year				
Bo he deat the at hed for	Phys	1 Yes 2 No 9 V Unknown 9 Unknown	[00- 5						
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death for the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn	þ			old tobacco use contribute to Yes 2 ✓ No 3 Pro					
ords w requires s been s should	lete		24a. V		utopsy findings available completion of cause of				
Reco The law cate has	Completed			erformed? death?  Yes 2 No 1 Y	es 2 No				
ital Recision: The certificate ector, page	Be (	25. Was case referred to medical 26 Place of Death examiner?							
n of Vir ling Physic After this funeral dire	: To	1 V Yes 2 No Impatient 2 V Ervoupatient 3 DOA 4	Nursing Home 5 k? 28d Descr	Residence 6 Other	er:				
ion c tending eath tor: Af	ation	1 Natural 5 Pending Jan 6, 2009 1402 hrs 1 Yes 2 ✓ Accident Investigation	Passeng	er auto auto collision					
Division of Vital Records, to the Hospital or Attending Physician: The law require within 24 hours after death To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	or Tow	on (Street and Number or R vn, State) south of Twin Arch Road					
Di Hospital 4 hours a Funeral I				····					
To the Ho within 24 F To the Fu	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death or and manner stated.							
F × F ŏ	Ă			29d. Date signed (M					
		Carol Hallar O.C.M.E.		January 7, 2007					
10		Name and address of person who completed cause of death (Item 23a)     Carol Allan, MD	21201						
	tate	31. Date filed (Month, Day, Year) 0 2007 32. Resistrar's Signature							
Regis	trar	JAN 9 2007 Fleur & Louis							

			1 - For State Registrar	State of M	arylan		artmen rtificat					- /	2007	016	557
	Dhusisi		1. Decedent's Name (First, Middle, Last)								2. Date of Deat Month		Voor	3. Time of	Death
	Physici /Medio			CHARLES	ELSWO	RTH SP	ANGLE	ER			January		2007	4:05	РМ
1	Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	of Death		4c.	County of Dear	th	
			Northampton Manor		Home			ederi				, F:	rederic	k	
	Funeral		5. Social Security Number 6. Sex	7. A		last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Co	hplace (State o	or Foreign
	Director		I		7	7 Yrs.					June 24	, 19	929 Mar	yland	
	and w		Usual Residence of Decedent  10a. State 10b. County	<del></del>	10c. City	, Town or Lo	cation					ary 5 2007  4c. County of D., Frederid Pirth. Pay Year) 24, 1929 Ma  10g. Citizen of What U.S.A. Black, W. Specify: W. Specify		10d. tnside C	ity Limits
	Aaryl Feho	ō	Manual and Employed	1_											2 No
	28a-	ect	Maryland , Frederic  10e. Street and Number	K	Fre	ederic	I 10f. Zip	Codo			1	0a Citi	zon of Milat Co	Λ	
	with with	ō	910 Pine Avenue					2170	1		1	og. Oili		outiny:	
	s 1 end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 le markad other than "natural", or Iteme 23a or 28e-f ehow other traumatic event, the Madical Examinational La notified at	Funeral Director		12. Was Decedent	Ever in U	S 13 1				ain? (Spe	or No.	1		rican Indian	
40	ter d	- L	1 Never Married 2 XMarried	Armed Forces' 1X Yes 2 □	?	3. 13.	f Yes, spec	cify Cubai	n, Mexicar	n, Puerto I	cify Yes or No- Rican, etc.)		Black, Whit		
336	urs al	b	3 ☐ Widowed 4 ☐ Divorced	tf Yes, Give Year or Dates:		3	1 🗆 Yes	2X□ No	Specify:				Specify: Wh	ite	
21215-0036	2 hou	Completed	15. Decedent's Edu	cation		16a. Dece	dent's Usua	al Occupa	ation			16b. Kir			
215	nin 7.	pie	(Specify only highest grade Elementary/Secondary (0-12)	completed) Cottege (1-4or	5.1)	(Give	kind of wo DO NOT u	rk done d se retired)	luring mos )	t of workir	ng			,	
21,	d with	E O	11	College (1-40)	3+)	A	ssist	ant	Manag	ger		Dru	ug Stor	es	
b	e filed other other	BeC	17. Father's Name (First, Middle, Last)				-		18. Mothe	r's Name	(First, Middle, M				
<u> a</u>	should be t and Mental b markad of umatic eve	ToE	Snively Elsworth S	pangler					Jess	sie E	lizabet	h Go	onso		
Maryland	2 should be filed withir and Mental Hygiene. Ie markad other than aumatic event, the Ma		19a. tnformant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	l Route Number	City or	Town, State,	Zip Code)	
	alth a		Ann Spangler / Wi	fe		910 P	ine A	venu	e, Fr	eder	ick, Ma	ry1a	and 217	01	
J.	of He itam		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of	o}	D	ate	20c. Lo	cation - City or	Town, State	
Ĕ	Page nent c nt: If ry or		1 ☐Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		. 01iv			)	/9/0	17 F	rada	ariok i	Marvilan	d
Baltimore,	permit. Pages 1 end 2 Department of Health a Important: If ttam 27 is any Injury or other tra <u>once.</u>		21. Signature of Funeral Service Licens	9	110							Leuc	ELICK,	rial y Lan	.u
ä	Depermine any Irreported		Kulter	Litt		12	BERT Ol No	E. D.	ALLEY MADEE	. & S	ON, FUNE	RAL	HOMES,	P.A.	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that cause	d the death								اللا والد	Approximat	е
	Physician		Immediate Cause (Final	e cause on each	110.									Interval Bet Onset and I	Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequ	ience of):	L							1 dly	
	Examiner											Day Year 5 2007  4c. County of De Frederi  Frederi  Year) 9. E  Year) 14. Race - Ar  Black, W  Specify: W  Inches Sumame)  Year  Year) 9. E  Year) 9.			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):									
	d d ansit	Examiner	Cause (Disease or injury that initiated events												
oʻ	exectan an an rial-tr	EX	resulting in death) Last	Due to (or as	a consequ	uence of):					<u> </u>				
8760,	The law requires that the death certificate be executed the has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	cai		l											
9	o ph as th	Physician/Medical													
Box	leath certifica ettending ph for use as th	N/S	tF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			3					2	3d. Date of del	ivery	
	deati	icia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a			]Ectopic pr ] Other <i>(sp</i>						Month	Day '	Year
P.0	that the de ned by the e	hys	9 ☐ Unknown	9□ Unknown									_		
	res the signed to	by P	Part II. Other significant conditions cor	tributing to death t	out not resu	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did tob	acco u	se contribute to	the cause of c	leath?
Records,	w require been sig should b	Pa	autiles me	leder							1 □ Ye	s 20	DNo 3□Pr	obably 4 🗆	Jnknown
00	s been should	Completed	Denetic								24a. Was a	)	24b. Were au	topsy findings	available
Re	The lay	E	1 1-17 1	114								red?/	prior to death?	completion of c	ause of
tal		O	25. Was case referred to medical	au	,				OC Diana	of Dooth	1		1 ☐ Yes	2 No	
of Vital	Physician: rthis certificatal director,	To B	examiner?	ospitat.	ent 2 🗆	ER/Outpatien	nt 3□ DC	Othe	· .	6	(Check only on		. Dorb /0-	- ( )	
	Phys or this oral di		27. Manner of Death	28a. Date of this		28b. Time of		Bc. trijury Work						ciry)	
Division	Attending I r death. ector: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	lnįury	М		.? ∕es 2 🔲 1	No					
Vis	Attendil r death. ector: A by the fu	Hice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At ho	me, farm, str	eet, factory	, office		2	28f. Location (St	eet and	d Number or Ru	ıral Route Num	ber,
Ö	affor afford in the	ert	4  Homicide determined	building, e	tc. (Specify	<i>(</i> )					City or Town	, State)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illed in by the funeral director.	ai C	29a. Certifier 1 Certifying Phys	sician: To the best	of my know	wledge, death	occurred	at the time	e, date an	d place, a	and due to the ca	use(s)	and manner as	stated.	
	P Hc	edicai	(Check only 2 Medical Examinations)	ner: On the basis of and manner si	of examinat	tion and/or in	vestigation	, in my op	pinion, dea	th occurre	ed at the time, da	ite and	ptace, and due	to the cause(s	)
	To to Withir To to comp	Me	29b. Signature and title of certifier		1	1	290	. License	number		25	d. Date	signed (Monta	h, Day, Year)	
			Then 9	1/16	eli	MA	9	130	149	6		11	8/0	7	
^.	Mex		30. Name and address of person who co	mpleted cause of	death (ttem	23a) (Type	Print)					- /			
J.	( )		Francis 6 1	Perker.	mo	1 30	OK	1 17	7/1	16	refere	k.	11/2	1701	
	Sta	ite	31. Date filed (Month, Day, Year)	32 Aegist	rar's Signat	ture					0,000	-/-	- 1 0 1		
	Registr	rar	IAN 0 9 200	17 1000	w K	T. 60	BALL!								

				Out (Maril				•		3	
			for State	State of Marylan				d Mental Hy	ygiene.	007	01658
			Registrar		Cei	rtificate c	of Death		Reg. No.	001	01000
	Physicia	an	Decedent's Name (First, Middle, Last					2. Date of D Month	eath Day	Year	3. Time of Death
	/Medic	_	Daniel Charles					ol	04	07	7:10AM
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	m, or Location of D	eath	4c. Co	ounty of Death	
			309 Manor Avenue			North				cil	
	Funeral		Social Security Number     6. S	MM 2□F		If Under 1 Ye Months Da		Hrs. 8. Date of B	irth Ja <i>y, Yəar)</i>	9. Birth Cou	place (State or Foreign intry)
	Director		1/1-20-5699	80	Yrs.			Jan.	16, 19	26 Peni	nsylvania
	and *		Usual Residence of Decedent  10a, State 10b, County	10c, Cit	/. Town or Lo	cation					10d. Inside City Limits
	Aaryl	ō									1 ☐ Yes 2 ☑ No
	28a-1	Director	Maryland Cecil  10e. Street and Number	No	rth Ea	10f. Zip Cod	40		10- 0::	(11/5-1.0-	
	hours effer deeth with the Maryland tural; or Items 23a or 28a-f show al Examinar must be notified at	ក់								n of What Cou	
	ss 23	Funeral	309 Manor Avenue	12. Was Decedent Ever in U.	C 121	219		2 (Consider Van or N		d State	
	Item Item	'n	1 ☐ Never Married 2 Married	Armed Forces?	i = 0	If Yes, specify (	Cuban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	14.	Black, White	
38	Il', or	by	3 Widowed 4 Divorced	1 X) Yes 2 □ No Mar If Yes, Give Year or Dates: 1944 —	1046	1 ☐ Yes 2 <b>汉</b>	No Specify:		S	pecity: Wh:	ite
5-0036	2 hou		15. Decedent's Ed	lucation	16a, Dece	dent's Usual Oc	cupation		16b. Kind	of Business/Ir	ndustry
215	within 72 ene. than "ne he Madic	ple	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give life.	kind of work do DO NOT use re	one during most of stired)	working			·· <b>,</b>
212	y the	Completed	12	College (1-401 5+)	Sa1	esman			Auto	mobile	
פ	e filed other vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middl			
<u>a</u>	Ald be Aental rked c	To E	George Jacob Sny	der			Nadir	e Tessie	Tyson		
Maryland 2121	should and Men marke umaric		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Str	reet and Number o	r Rural Route Num	ber, City or T	own, State, Zi	p Code)
	s I and 2 should be filed within 72 hours efter deeth with the Marylan f Heelith and Mantal Hygiens. If Heelith and Mantal Hygiens is the fire that is marked other than "netural", or Items 23a or 28a-f show other treumatic event, the Modical Examinar must be notified at		Yvonne T. Snyder	/ Wife	309	Manor A	Avenue, N	lorth Eas	t, Mar	yland	21901
J.	of Hee		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name or matory or other	f   Ta	Date	20c. Loca	tion - City or T	own, State
Ë	permit. Pages Depertment of Important: If It eny injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Control of the C	Helitoval Itolii State		Cemete	1	2007	Risin	o Sun	Maryland
Baltimore,	permit. Depertm Imports eny inju		21. Signature of Juneral Service Lity	Syl			delease of Families				naryzana
m	Depe Impo eny i		Valory Co	art				Crouch Fu			1 1 0100
			23a. Part1. Enter the disease, or com	plications that caused the death	n. Do not ent	er the mode of	dying, such as car	diac or respiratory	arrest,	ast, Ma	ryland 2190 Approximate
	Physician	1	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		A		1.	_	0	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequence	NY	TVT	eng	NI >	eor		unknown
4	Examiner		1	Due to (or as a consequ	derice of .		1				
		e	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
,	be executed icien and burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	uence of):						
760,	eath certificate be executed ettending physicien and for use as the burial-transit	cai		d							
9	ificat g phy as th	-							1		
Вох	ndin use	S	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome of pregna					230	d. Date of deliv	erv
m	death d for	Icla	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		]Ectopic pregna ] Other (specify				Month	Day Year
O.	by the destached	hys	9 Unknown	9□ Unknown							
ت. ح	The law requires that the death certifica sie hes been signed by the ettending ph bage 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions of	ontributing to death but not resu	ılting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use	contribute to I	the cause of death?
Records,	n sig							1 🗆	Yes 2 □ I	No 3 Pro	bably 4 Unknown
Ö	w require been signal	Completed						24a. Wa	s an	24h Wara aut	opsy findings available
He	he la e hes ige 2	μŽ						- auto	opsy formed?	prior to co	ompletion of cause of
Vitai		ပိ	25. Was case referred to medical					1 Yes		1 🗆 Yes	2016
	rsician: The law s certificete hes t lirector, page 2 s	8	examiner?	Hospital:	5B/0:	-5-01	Other	Death (Check only			
ō	Physic refisers of dispersion of the second di	. To	27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	IL 3 DOA	4 LI Nursin	ng Home 5 Res			fy)
o	ding R	to	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		njuryat Work? 1 ∐ Yes 2 ∐ No				
Division of	Attender death	fica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At ho	me, farm, str			28f. Location	(Street and N	Vumber or Rur	al Route Number,
á	efte Dfr	Certification:	4 Homicide determined	building, etc. '(Specify	")				own, State)		
	e Hospital or Attending Physician: 24 hours eller death Pruncel Director: Atten this certific etely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wiedge, deati	n occurred at th	e time, date and p	lace, and due to the	e cause(s) ar	nd manner as s	stated.
	24 Fu	Medical	(Check only 2 Medical Examone)	niner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in n	ny opinion, death o	occurred at the time	, date and pl	ace, and due t	o the cause(s)
	To the Hospital or within 24 hours effe to the Funeral Difference of completely filled in	ž	29b. Signature and title of certifier			29c. Lic	ense number		29d. Date 5	signed Month,	Day, Year)
					0-	Do	0564	49	1/4	410	7
	HAIVA		30 Name and address of person who	completed cause of death (Item	23a) (Type,		0		2 1-	11/1	
	Land 1 8 1 11		111	212 [1]	11	$1/H \times 1$ .	JI C	ute 300	X DI	VI.	111171071
	7,111		sloria dimor		wes	+ High	101.00	ules		L IDVI	My) 01704
	Sta	te	31. Date filed (Month, Day, Year)  IAN 08, 2007	32. Registrar's Signa	wes.	+ ttigh	101.00	ules		DIEN	MUDAITAI

State

Registrar

31. Date filed Month, Day,

Year,

**JAN 08** 

200

32. Redistrar's Signature

			For State Registrar	State of M	Maryland /		nent of F cate of	lealth and M <i>Death</i>		iene •g. Nd2 0 0 7	01660
	Physici	an	Decedent's Name (First, Middle CAROL ANN TRA)						2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution		or)	4b	City, Town, o	r Location of Death	Januar	4c. County of Dea	TUTTO
	Exami		DORCHESTE	R GENE	1 4 0	(	CAM	BRIDG	E	DORC	HESTER
1	Funeral		5. Social Security Number	6. Sex 7. / 1 ☐ M 2 🛣 F	Age (In yrs. last I	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bi	rthplace (State or Foreign ountry)
4	Director		224-46-9929 Usual Residence of Decedent		69	Yrs.			AUG. 14	,1937 VIR	GIÑIA
2	aryland •how		10a. State 10b. County		10c. City, To	wn or Location	n				10d. Inside City Limits
SS	the Maryland 28a-f ehow notified at	ctor	MARYLAND DORCH	ESTER	EAST	r new 1	1ARKET				1 ☐ Yes 2 X No
10	with the	Funeral Director	10e. Street and Number			1	Of. Zip Code	0.1	1	Og. Citizen of What C	ountry?
K	death with me 23a or	era	3907 JAY COURT	12. Was Deceder	nt Ever in U.S.	13. Was	216 Decedent of H	Ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Am	
CAROL 21215-0036	within 72 hours after one. ene. then "nature!", or ite. he Medical Exemine.		1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Force ied 1 Tes 2 de lif Yes, Give Year or Date:	No No		s, specify Cuba ∕es 2.X.No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	ite, etc. WHITE
5.0	72 ho 'natur	eted	15. Decedent (Specify only highes	's Education it grade completed)	16	Sa. Decedent'.	of work done	during most of work	ing	16b. Kind of Business	s/Industry
121 A	within and then	Completed by	Elementary/Secondary (0-12)	College (1-4d	or 5+)	ife. DO N ASSEMB	IOT use retired	1)		MANUFACTU	IRTNC
92	00 -	ဝင္	17. Father's Name (First, Middle,	Last)		TO DILLID	DIK	18. Mother's Name	a (First, Middle,	Maiden Sumame)	RING
a A	should be and Mental ie marked c	To Be	FREDERICK DOWNE	Y				MYRTLE			
Baltimore, Maryland	d 2 should th and Men 7 ie marke treumatic		19a. Informant's Name/Relations		15					r, City or Town, State,	
P. A.	item 27		JOHN L. TRADER/S	SON	20h Place	28 ALO of Disposition				, MARYLAND 20c. Location - City o	
No.	permit. Pages: Depertment of h important: if its any injury or of		1 Burial 2 □ Cremation	3 □Removal from Sta	te ceme	tery, cremato	y or other plac	ce)			
i	entme ortan injury		4 □ Donation 5 □ Other (S	and the same	MD VE	ETERANS 22. Na		1/5/2		BEULAH, MA	
/ mg	permit. Deperti import any inj once.		Menard.	a sule	1	ZEL1 106	LER FUN MAIN S	ERAL HOME TREET, EA	ST NEW	BOX 207 MARKET MD	21631
3760,	Physician /Medical Examiner  be paragraph and purial-transit paragraph.	ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — A Due to (or a	as a consequence	Caren	om a	15 1	1510A		
Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certificat r death. setter: Aller this certificele has been signed by the atlending phy by the funeral director, page 2 should be detached for use as thi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal dea		opic pregnancy er (specify) _	,		23d. Date of de Month	Blivery Day Year
rds, P	quires that in signed t uld be det	Ď	Part II. Other significant condition	ns contributing to death	n but not resulting	g in the under	ying cause giv	ren in Part I.			to the cause of death?  Probably 4 hknown
al Reco	: The law requir cete has been s page 2 should	Completed							24a. Was a autops perform	y prior to	
Vit	sicien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			C DOA Oth	26. Place of Deat			
ţ	g Physical dispersed dispe	7. To	1 ☐ Yes → No  27. Manner of Death	28a. Date of In		. Time of	DOA 28c. Injur	4 □ Nursing Ho		ence 6 Other (Spa	ecify)
ion	ttending (death.ctor: Alter	atlo	1 Natural 5 Pendin 2 Accident investig		Day Year)	Injury !		k? Yes 2 □ No			
Divis	s after de si Diracto ed in by th	Certification;	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 289. Place of	Injury - At home, etc. (Specify)	farm, street,	actory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier Certifyin (Check only one) Certifyin	g Physician: To the be Examiner: On the basis and manner	of examination	dge death uot and/or investi	unted at the til gation, in my d	na date and place, pinion, death occur	and dua to thate red at the time, d	auco(c) and main of a late and place, and du	e to the cause(s)
	To 1 To 1 Com	Σ	29b. Signature and title of certifie	11 -			29c. Licens	e number	2	9d. Date signed (Mon	nth, Day, Year)
			cayine 1	1/cm 02	>		175	1143		1/2/07	2
			30. Name and address of per on	wno completed cause o	or death (Item 23a	a) (Type, Print	Bus	n St /	ambo	der m	0 2/6/3
3	Sta		31. Date filed (Month, Day, Year)	0 5 30. Regi	star's Signature		1 10		7911		
- 1	Regist	rar	JAN	0 5 2007	Weller.	St. A	المصورة				

State of Maryland / Department of Health and Mental Hygien $\mathbf{e} \subseteq \mathbb{U}$ 

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year **Physician** 5:30P January 2007 Patricia Ann Tolliver /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 M 2 XF Jan. 29, 1952 Wash. DC 54 Director 577-74-2153 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County or than "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Directo Washington DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20019 United States 838 - 52nd St., NE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status hours after African 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify ۵ 3 ₩ Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) Teacher Aide Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental ant: If item 27 is marked o Virginia Franklin Alfred E. Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3298 Ft. Lincoln Dr., #532, Wash., DC 20018 Virginia F. Palmer/Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: If any injury or once. Quantico National Cem. 1/17/2007 4 ☐ Donation 5 ☐ Other (Specify) Triangle, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home Lewar 4001 Benning Rd., NE Wash., DC 20019 23a. Part 1. Inter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Collise (Final disease or condition resulting in death) TRAUMATIC INTRACRANIAL NON Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): physician s the burial by Physician/Medical attending pl 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) o been signed by the should be detached 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မှ 1 ☐ Yes 2 No this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certi 3 death (Item 23a) (Type, Print) noleted cause o CHEVERLY, MD 20785 ooled 32. Redistrar's Construe State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of M		partment of F <i>ertificate of</i> I			liene <sub>eg. No</sub> 2         7	01662
	Physici	an	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	Day Year	3. Time of Death 4:00 P <sub>M</sub>
	/Medic	al	UY NANG TR 4a. Facility Name (If not institution,		r)	4b. City. Town, or	r Location of Death	JANUARY	2, 2007 4c. County of Dea	
	Examin	er	HOLY CROSS H		,		VER SPRING		MONTGOME	
	Funeral Director		214-51-8860	6. Sex 1 🛣 M 2 🗆 F	Age (In yrs. last birthd 52 Yrs	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day JULY 8,		thplace <i>(State or Foreign</i> ountry) /IETNAM
	rland ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	a-f sh	ctor	MARYLAND MONTGO	MERY		SILVER	SPRING			1 ☐ Yes 2 No
	vith the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	eath v	Funeral	14655 TYNEWICK	TERRACE 12. Was Deceden	nt Ever in U.S.	3. Was Decedent of H	20906 ispanic Origin? (Sp	ecify Yes or No-	U.S.A.	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	<u>م</u>	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒ Divorced	Armed Forces	No	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	te, etc. ASIAN
2-0	72 hc "natul dical	eted	15. Decedent' (Specify only highes	s Education t grade completed)	16a. De	cedent's Usual Occup ive kind of work done e. DO NOT use retired	ation during most of work	ing	16b. Kind of Business	/Industry
121	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or	r 5+)	e. DO NOT use retired  MAINTENANC			LANDSCA	APE
	2 should be filed and Mental Hygi is marked other aumatic event, the	Be C	17. Father's Name (First, Middle, I					e (First, Middle,	Maiden Surname)	
ylaı	should b and Ments marked umatic e	T <sub>O</sub>	THANH TRAN		ī			PHAN		
Maryland	nd 2 sh Ith and 27 is m traum		19a. Informant's Name/Relationsh	. ,		,			r, City or Town, State,	
	s 1 and 2 f Health item 27 i		PHI N. TRAN - Solution		20b. Place of Di	Sposition (Name of crematory or other place	i	-	RING, MARYLAN 20c. Location - City of	
imo	Pages nent of I ant: If ite ury or o	3	1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		e	EAVEN CEMETEI	i i	/2007	SILVER SPRIN	G, MARYLAND
Baltimore,	permit. Departm Importa any Inju		21. Signatur of Phyral S. Lee	A Horas	CFSP	22. Name and Addre HINES-RINALD 11800 NEW HA	I FUNERAL H		ER SPRING, MA	ARYLAND 20904
	r		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. Do not line.					Approximate Interval Between
Ç.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- C	TASTATIC LUNG	G CANCER				Onset and Death
	Examiner		,	Due to (or a	as a consequence of):					
_	T +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Due to (or a	as a consequence of):					
	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to for s	as a consequence of):					
68760,	tificate be executed ig physician and as the burial-transit			d.	is a consequence or,.					
	rtificat ng phy as th	Medical	IF FEMALE:				•			
.O. Box	the death certify the attending ched for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death	3 □Ectopic pregnanc; 5 □ Other (specify) _	/		23d. Date of de Month	elivery Day Year
<u>α</u>	w requires that the de been signed by the should be detached	þ	Part II. Other significant condition	ns contributing to death	but not resulting in th	e underlying cause giv	en in Part I.	23e. Did to	bacco use contribute t es 2 □ No 3 🗓 F	to the cause of death?  Probably 4 Unknown
or Vital Records,	The larate has	Completed						24a. Was a autop: perfor 1 Yes	sy prior to med? death?	utopsy findings available completion of cause of s
V Its	Physician: The this certificate I ral director, page	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:	** 0ETED/O.4	tiont 2000A Oth	26. Place of Deat			
0	g Physer this	n: To	27. Manner of Death	28a. Date of In (Month, D	njury 28b. Tim	e of 28c. Inju	4   Nursing Ho		ence 6 Other (Sp.	ecify)
sion	Attending r death. ector: After by the funer	atio	1 XNatural 5 Pending 2 Accident investig	ation	<i>Day Year)</i> Inju		Yes 2 □ No			
Division	or Att after de Direct in by (	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	inad   Zoe. Place of I	njury - At home, farm etc. (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Co		g Physician: To the bes Examiner: On the basis and manner:	of examination and/o					
	To the within 2 To the complet	Me	29b. Signature and title of certifier		awas-	29c. Licens		2	29d. Date signed (Mor	nth, Day, Year)
	1		<i>e</i>	1.0.1100		DS	0987		1-2-	07.
	-		30. Name and address of person of A HWRD H	AW AZ 1	Fo Box	B3819	Gail	xrsbu	1 - 2 - 2 - 29 mo	20883
	Sta Regist		31. Date filed (Month, Day, Year)	5 2007 <sup>32. R</sup>	strar's Signature	boartes				

DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - For State Registrar	State	of Maryla	-	artment of lartificate of			lental		enez ()	07	01663
			1. Decedent's Name (First, Middle, I	Last)						2. Date of		Day	Vaar	3. Time of Death
	Physici		LUVENDA C. TALLI	EΥ						JANU			Year 007	8:00A M
1	/Medic Examin	_	4a. Fecility Name (If not institution, g	ive street and no	ımber)		4b. City, Town,	or Location of	of Death			4c. County	of Death	
			HOLY CROSS HOSP	TAL			SIL	VER SP	RING			MON	TGOME	ERY
	Funeral		Social Security Number 6	. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of	f Birth	(ear)	9. Birthp	lace (State or Foreign
	Director		155 01 7721	1 □ M 2XXF	8	35 Yrs.	Month's Days	Hours		MAR.	26,	1921		JERSEY
	P .	{	Usual Residence of Decedent		100.0	No. Tour								Od toold Ob High
	anyla	_	10a. State 10b. County		100.0	City, Town or Lo								0d. Inside City Limits  XX Yes 2 □ No
	Ba-f	cto	DC			WASHING					1			
	ith th	Director	10e. Street and Number				10f. Zip Code				10	g. Citizen of 1	What Cour	ntry?
	ath y	Funeral	426 FARRAGUT STI					0011					ED ST	
	er de	nue	11. Marital Status	Armed F		U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Ori an, Mexicar	igin? (Spe n, Puerto	ecify Yes o Rican, etc	or No- )		e - Americ ck, White,	
36	tiled within 72 hours after death with the Maryland Hygiene. other than 'natural', or iteme 23a or 28a-f show ent, the Madical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married  XX Widowed 4 ☐ Divorced	If Yes, G	<b>2√1</b> XNo ive		1 □ Yes XX No	Specify:				Specif	BLAC	CK
Ş	hour	DE LE	15. Decedent's	Year or	Jaies.	162 Daga	dent's Usual Occu	nation			1	6b. Kind of B	ucinace/la	duota
21215-0036	n 72	Completed	(Specify only highest	grade completed		(Give	kind of work done DO NOT use retire	during mos	t of work	ng	"	DD. KING OF D	23110337111	Justry
7	withi ene. ther	E	Elementary/Secondary (0-12) 12TH	College	(1-4or 5+)		RETARY	,				PENT	A CON	
9	Hygi Hygi other		17. Father's Name (First, Middle, La	st)	_	) DEC	ALIANI	18. Mothe	er's Name	(First, M	iddle, M	aiden Suman		
Maryland	ental ked c	To Be	CORNELIUS COLEMA	M				RII	ד אידו	OHNSO	M			
2	Shou nd M mari	-	19a. Informant's Name/Relationship			19b. Maili	ng Address (Stree	-				City or Town,	State, Zip	Code)
Š	Ith a		LEMUEL T. TALLEY	/ SON		104 1	MADISON S	ST. NW	W	ASHTN	JGTO	N, DC	20011	
<u>6</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than 'natural', or iteme 23a or 28a-f show way fourry or other traumatic event, the Madical Extension must be notified at once.		20a. Method of Disposition		i	Place of Dispo	sition (Name of			ate		Oc. Location -		
20	ages ant of t: If i		1 Maurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		State H A		matory or other pla MEMORIAL		01/1	3/200	37	LANDO	VER	MD
altimore,	ortan frijur		21. Signatore of Fundral Service Lice		111						_			
æ	Depermine on the poor		N N	laust	00	l I	MARSHALL 4308 SUI:	S FUN	ERAL	HOME		MARYL AND, M		
			23a. Part 1. Enter the disease, or co	mplications that	caused the de								<u>D 207</u>	Approximate
	Dharistan		shock or heart failure. List on Immediate Cause (Final							,				Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	a	(or as a conse	NARY A	RREST							
	Examiner					OVOLEMI	7)							
	*	er	Sequentially list conditions, if any, leading to immediate	D	(or as a conse		3)							
	uted ansit	F	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	ACTT	VE ACIII	re gi bi	EEDING							
<u>.</u>	exection and in and inal-tra	Examiner	resulting in death) Last	V	(or as a conse									
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89	tificat ig phy as th													
Вох	leath certifi attending   I for use as	N/M	IF FEMALE: 23b. Was decedent pregnant		tcome of preg		Je					23d. Da	te of delive	ery
	death e atte d for	icia	in the past 12 months?	4□Preg	binth 2 ∐ Fe nantattime of		]Ectopic pregnanc ] Other (specify) _	;у			_	Mo	nth	Day Year
0	that the de led by the a detached i	hys	9 Unknown	9□ Unk	nown									
ري ح	The law re-uires that the death certifications is that been signed by the attending of get 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying cause g	ven in Part I		23e.	Did toba	icco use cont	ribute to th	ne cause of death?
Ĕ	w require been sig should b	ed t									1 🗌 Yes	2 □ No	3 ☐ Prob	ably XXUnknown
8	aw requast belon 2 should	oiet									Was an	24b.	Were auto	psy findings available
Vital Records,	The lay	E									autopsy perform	ad?	prior to cor death? I 🔲 Yes	inpletion of cause of
ā		0	25. Was case referred to medical		_			26 Place	of Death	Check	es X		162	2L] NO
		To B	examiner? 1 ☐ Yes XX No	Hospital:XX	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	har			SC-110- 433	ce 6 ⊟Oth	er (Specifi	<b>(</b> )
Division of	문문교	ë	27. Manner of Death		of Injury oth, Day Year)	28b. Time o	f 28c. Inju	ry at				injury occur		.,
<u>0</u>	Attending r death. ector: After by the fune	atio	XIXNatural 5 ☐ Pending 2 ☐ Accident investigat		IIII, Day 19ar)	Injury		ork? ]Yes 2∐	No					
<u>×</u>	Atts or de octo by th	2	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	286. Plac	e of Injury - At	home, farm, st	reet, factory, office						er or Rura	l Route Number,
ō	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Attercompletely filled in by the funer	Certification:	·	Dulid	ling, etc. <i>(Spe</i>	<b>y</b> /				Uny o	r Town,	ciaid)		
	Hospital		29a. Certifier XX Certifying	Physician: To th	e best of my ki	nowledge, deat	h occurred at the t	ime, date an	nd place,	and due to	the cau	ise(s) and ma	inner as st	ated.
	he Hin 24 he Fi	Medicai	one)	and ma	nner stated.	nation and/or in	vestigation, in my	оріпіоп, беа	un occurr	ed at the t	ime, dat	e and place,	and due to	me cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	ATO			29c. Licen	se number			29	d. Date signe	d (Month,	Day, Year)
	(10)		> 100	No.	N	LD.	DO	006410	0			JANUA	RY 05	2007
	an		30. Name and address of person wh	no completed cau			Print)							
	16		SMITHA BHIKKAJI	M.D.	1	500 FO	REST GLEI	N RD.	SIL	VER S	SPRI	NG, MD	2091	.0
	Sta		31. Date filed (Month, Day, Year)	32,	Registrar's Sig	b. Sp	J.							
	Registr	ar	JAN 082	JUI E	cum 1	J. Sp.	and the same							

			For State Registrar	State o	of Maryland	•	artment rtificate			and M		giene Reg. No.	07	016	64
	Physicia		Decedent's Name (First, Middle,     PAULINE MARIE								2. Date of De Month Januar	Day	Year 007	3. Time of E	
	/Medic Examin	_	4a. Facility Name (If not institution, South River Nu	give street and nu		nter		Town, or Igewa	Location o	of Death	ballsag	4c. Coun	y of Death		
	Funeral Director		5. Social Security Number 217–36–5443	3. Sex 1 □ M 2 🛣 F	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under Months		If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da July 17	th y, Year) , 1918		olace (State or ntry) nington,	
	Maryland I-f show	L	Usual Residence of Decedent  10a. State 10b. County			, Town or Lo			<u> </u>				1	0d. Inside City	
. )	ith the Marylan or 28e-f show	Directo	Maryland Anne A		Ed	lgewat	10f. Zip					10g. Citizen of			
UCHER -0036	after death with the or Items 23a or 28e	Funeral Director	144 Washington  11. Marital Status  1 Never Married 2 Marrie	12. Was Dec Armed Fo d 1 Tyes	2 📉 No	S. 13.	Was Deced If Yes, spec				ecify Yes or No Rican, etc.)	BI	ice - Americ ack, White,		
70C6	be filed within 72 hours after trait Hygiene. d other than "natural", or ite event, Le Medical Erasitre	by	3 🕅 Widowed 4 □ Divorced  15. Decedent' (Specify only highest	If Yes, Gi Year or D Education grade completed)	Dates:	16a. Dece	1 ☐ Yes :	I Occupa	Specify: ation during mos		ing	Spec 16b. Kind of	MI	nite <sub>dustry</sub>	
	be filed within ital Hygiene. Id other than event, In Me	Completed	Elementary/Secondary (0-12)	College (			DO NOT us emaker				e (First, Middle,	Own I			
Narvland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, ILM M	To Be	17. Father's Name (First, Middle, L Eugene Jones			405-14-7		(21	Ann	ie M	. Pears	on		Codel	
	5 2 € g		Joseph O. Tuck			804	Crand	le11	Road	, We	al Route Numbe st Rive Date	-	land	20778	
P.A.U.	mit. Page: partment o portent: If y injury or		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.  21. Signature 1 Furnal Service L	ecify)	State	1	coln (	emete d Addres	ery ss of Facilit	1/9/ by		Brentw 4739	ood, Balt	Marylar imore	Ave.
68760		edicai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	(or as a consequ	ESTI lience of): lience of):	VE I	HEN	RT	F	ALU J	R/E		Approximate Interval Betw Onset and D	eath
G BOX	ne death certificat	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊇ No 9 □ Unknown	1 ☐Live	itcome of pregnal birth 2 ☐ Fetal nant at time of de nown	death 3	□Ectopic pr □ Other <i>(sp</i>						ate of deliving		ear
D D	quires that the d	þ	Part II. Other significant conditio	ns contributing to c	death but not resu	afting in the t	underlying c	ause give	en in Part I		23e. Did t	obacco use co Yes 2 100		he cause of de	
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Division of Vital Records P.O. Box	To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Certification; To Be C	25. Was case referred to medical examiner?  1  Yes	28a. Date (Mor	Inpatient 2 1 of Injury nth, Day Year) e of Injury - At ho ding, etc. (Specify	28b. Time of Injury	of 2	8c. Injury Work 1 🗆 '	er:	ırsing Ho	h (Check only come 5  Residue) 28d. Describe   28f. Location (City or Total	dence 6 00 how injury occu	ırred		oer,
	Hospitel or 24 hours affe Funerel Dir etely filled in	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the ixaminer: On the land man	e best of my know basis of examinat nner stated.	wledge, dea tion and/or ii	th occurred nvestigation	at the tim , in my of	ne, date ar pinion, dea	nd place, ith occurr	and due to the red at the time,	cause(s) and r date and place	nanner as s e, and due t	tated. o the cause(s)	
	To the To the To the Comple	Me	29b. Signature and title of Cartifier	~@_	- M	Φ.		License D 5	13	13		29d. Date sign	oed (Month,	gay, Year)	
	ge		30. Name and address of person of the state	who completed cau	use of death (Item  8 2  Megistrar's Signal	7 (	i~£	En	5	WE	31	Min	14RE	210	201
	Sta Regist		JAN 0 8 2007	haven	o. Loc	K	·								

			1 - For State Registrar	State of Maryland /		artment of F		nd Mental H	ygien Reg. N	/ 111	7	01665
	Physici	ian	1. Decedent's Name (First, Middle, Last	)				2. Date of I		ay	Year	3. Time of Death
	/Medi	cal	L. Joyce Titus					Janua		•	007	15:25PM
	Examir	ner	4a. Facility Name (If not institution, give Union Hospital of	,		4b. City, Town, or		Death	40	c. County o		-3 ( 23 1 1 1
	Funenal		5. Social Security Number 6. Sec		irthda v)	E1kto		4 Hrs. 8. Date of E	2:45	Cec		
	Funeral Director			<sup>2</sup> M 2 € 78	Yrs.	Months Days	Hours	Min. (Month, I	Day, Year	7	Coun	lace (State or Foreign htry) h Carolina
	P		Usual Residence of Decedent					oury 2	-1, 1	. 720 1	.,01. 61	i CalUIIIIa
	arylar show	_	10a. State 10b. County	10c. City, To	wn or Lo	ocation					1	0d. Inside City Limits
	Sa-1-	Director	Maryland Cecil	Nort	h E	ast						1 ☐ Yes 2 No
	with t	급	10e. Street and Number	D 1		10f. Zip Code			_	itizen of Wi		*
	eath	Funeral	872 Turkey Point	12. Was Decedent Ever in U.S.	112	2190		-0/C		ited S		
0	fler d	Fun	Never Married 2 Married	Armed Forces?	13.	If Yes, specify Cuba	n, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	10-		- Amenc , White,	an Indian, etc.
ğ	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2\overline{X}No	Specify:		-	Specify:	Wh:	ite
21215-0036	I be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23s or 28s-1 show sevent, the Madical Examiner must be rigitlisd at	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a	. Dece	dent's Usual Occupa	ation	of working	16b. F	Kind of Bus	iness/Inc	dustry
2	hen .	mpf	Elementary/Secondary (0-12)	College (1-4or 5+)	_	kind of work done of DO NOT use retired		oi working				
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Maryland	ntal H	Be	Walter Fowler					s Name (First, Middl		ı Sumame,	)	
2	d Me mark matic	၉	19a. Informant's Name/Relationship (Ty	na Print)	h d a little	Add (8)		ilsie Morn				
<u>B</u>	permit. Pages 1 and 2 should b Department of Health and Menta Important: If tem 27 is marked any injury or other traumatic a once.							or Rural Route Num				
စ်	f Hea		Melvin Douglas Tit: 20a. Method of Disposition	20b. Place of	of Dispo	sition (Name of		North Ea		Mary 1 ocation - C		
daltimore,	Pages ent of nt: If I		1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place Cemetery	J	anuary			•	
	mit. partmoorta		21. Signal 4 of Funeral Service Liven				. 4	, 2007 Crouch Fu	Clar	ksbor	0.1	lew Jersey
ă	Depa Depa Impo eny ir		Called H. C	was	1:	27 South	Main 9	Street No	nera	T HOM	ne Mar	yland 2190
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	cations that caused the death. Do	not ente	er the mode of dying	, such as c	ardiac or respiratory	arrest,	nast,	_ Flai	Approximate
	Physician		Immediate Cause (Final disease or condition	Ca. die	AD P.	1100	De a	ol.				Interval Between Onset and Death
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	ficate g physi	edical		•								
Š	thet the death certificated by the attending to detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy						23d. Date	of deliver	
0	deatl	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death		Ectopic pregnancy Other (specify)				Month		Day Year
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'n	sicien: The law requires the certificate hes been signed rector, page 2 should be de	5	Part II. Other significant conditions con	tributing to death but not resulting i	n the un	. 1		23e. Did	tobacco i	use contrib	ute to the	e cause of death?
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5	lending Physician: The leath.  Tor: After this certificate his the funeral director, page	2	1 Yes 2 No	ospital: 1 npatient 2 ER/Ou			4 🗆 14012	ing Home 5□Res				
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3	after after Dire	Certification	4 Homicide determined	building, etc. (Specify)	iii, sire	et, ractory, office		City or To	wn, State	a Number (	or Hural	Route Number,
:	To the hospital or Attending Physician: The law requires that the death certification 24 hours after debut sortificate has been signed by the attending to the Funaral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	aic	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge	, death	occurred at the time	a. date and	place, and due to the	Callee(e)	and mann	or ac cta	tod
:	na Ho n 24 ha Fu	edicai	(Check only 2 Medical Examin	er: On the basis of examination an and manner stated.	d/or inv	estigation, in my opi	nion, death	occurred at the time,	date and	place, and	d due to t	he cause(s)
1	To t	Σ	29b. Signature and title of celtifie	0		29c. License			29d. Dat	te signed (A	Month, D.	ay, Year)
			1 60 /1VA	exc	-	DO	1213	78	l	10	0	7
	0		30. Name and address of person who cor					25	, ,			-
•			2300 Pen 31. Date filed (Month, Day, Year)	7300	111	neingti	2	NT_	15	1 80	6	
	Stat Registra		IAN 08 2007	82. Registrar's Signature	nest	ريح					, -	

07-00244 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joseph A. Verrier 1- For State Certificate of Death Registrar 1, Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 2239 hrs **Medical Examiner** Joseph Arthur Verrier January 8, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 16414 Pennsbury Lane Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7 Age (In vrs. last birthday) **Funeral** Months Days Hours Cambridge, MA Director 030-48-3320 49 Dec.30,1957  $\mathbf{X}_{\mathsf{M}}$ Usual Residence of Decedent 10a State 10c. City, Town or Location 10d Inside City Limits MD Prince George' Crofton Yes 2 X No 28a-f show hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country fied at 21114 USA 16414 Pennsbury Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black 11 Marital Status White, etc Armed Forces? 1 Never Married 2 Married Yes White 1 Yes 2 No specify Widowed Divorced If Yes, Give Year Specify ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 721 Department of Health and Mental Hygiene Importants If item 27 is marked other than "mjury or other tranmatic event, the Medical Elmjury or other tranmatic event, the Medical Baltimore, MD 21215-0036 2 Metal Worker Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul H. Verrier Dorothea West 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 Page Road Bedford, Massachusetts 01730 Paul H. Verrier/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State 1/13/07 Shawsheen Cemetery Bedford, MA. Other \$pecify Donation 5 ure of Funeral Se 22 Name and Address of Facility PHILIP D.RINALDI FUNERAL SERVICE, P.A. Columbia Blvd Silver Spring Md20910 de of dying, such as cardiac or respiratory arrest, shock, or heart proximate Interval er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he **Physician** failure. List only one cause on each line Retween Onset and /Medical Death Complications of chronic alcoholism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical ding physician a X UNPENDED AMENDED #23a,27,perME, g863, 1/25/07 TT O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live buth 3 Ectopic pregnancy Month Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Yes 2 No 3 Probably 4 ✔ Unknown Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 2 No 1 🗸 25. Was case referred to medical 26 Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Other<sub>4</sub> Hospital. Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this 1 🗸 Yes 2 ۵ No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c Injury at Work? 28d Describe how injury occurred Certification: X Natural 5 Pending Yes 2 No 2 Investigation Accident 28e Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only To the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. January 9, 2007 ronce Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

Registra DHMH 17 Rev 1/2001

OCME 2006

State

31. Date filed (Month, Day, Year) JAN 18 2007

Registrar's Signature

Physician /Medical Examiner

within 24 hours a

Division or Vital Records, P.O. Box 68760.

	4 Donation 5 Other (Specification 5 Donation  Metropolitan Crematory 01/06	5/2007 Alexandria, VA.	
	21. Signature of Funeral Service Licer	see 22. Name and Address of Facility Bea	all Funeral Home
	Coman	6512 NW Crain Hwy.	Bowie, MD. 20715
	shock, or heart failure. List only	1	respiratory arrest, Approximate Interval Between The Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	AMOUNTS
Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):	
dice	•	,d.	
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year
ed by PI	Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
Complet			24a. Was an autopsy performed?  1 Yes 2 No   24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Be (	25. Was case referred to medical examiner?	26. Place of Death (	Check only one)
2	1 ☐ Yes 2 No		e 5 Residence 6 Other (Specify)
ation:	27. Manner of Death  1 Natural 5 ☐ Pending  2 ☐ Accident investigation	(Month, Day Year) Injury Work?  M 1 □ Yes 2 □ No	ld. Describe how injury occurred
ertific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	ff. Location (Street and Number or Rural Route Number, City or Town, State)
Medical Certification: To	29a. Certifier 1 McCertifyIng Ph (Check or) 2 Medical Exar	ysician: To the best of my knowledge, death occurred at the time, date and place, an niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
Ž	29b. Signature and title of certifier	DLB364	29d. Date signed (Month, Day, Year) 01 05 2007
+	Name and address of person who	complete cause of death (Nem 23a) (Type, Print)	nWADUS WD ZILDI

State Registrar 31. Date filed (Month, Day, JAN 0 9 2007

			1 - For Stata Registrar	State of M	laryland /	•	artmen rtificate			and M		jiene	007	01668
	Physici		1. Decedent's Name (First, Middle, La	1 /	HLEN	DE					2. Date of Dea	th Day	Year	3. Time of Death  02/0 M
	/Medic Examir		4a. Facility Name (If not institution, giv Eldercare Garden	street and number			4b. City, Lint		Location o	of Death		-	County of Deat	
	Funeral Director		5. Social Security Number 6. S 129 07 8009 1 Usual Residence of Decedent	ex 7. A	ge (In yrs. last 89	birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth 5 av 3/1/191	7 ( Year)	9. Bird New	nplace (State or Foreign unto) YORK
	y within 72 hours after death with the Maryland liene. r than "netural", or Items 23a or 28e-f show the Mudical Evandrat must be notified at	Funeral Director	10e. Street and Number 302 Chestnut Rd.  11. Marital Status	Arundel  12. Was Deceden	t Ever in U.S.	nthi	CUM 10f. Zip 2	1090		gin? (Spe	ecify Yes or No- Rican, etc.)		en of What Co USA  4. Race - Ame Black, White	rican Indian,
d 21215-0036	within jiene.	Completed by	1 Never Married 2 Married 3 Noted 4 Divorced  15. Decedent's E. (Specify only highest grave) Elementary/Secondary (0-12) 11  17. Father's Name (First, Middle, Last,	de completed) College (1-40)	16	Ba. Dece (Give life.	dent's Usua kind of wor DO NOT us ecret	l Occupa k done d e retired,	luring most		ng ı (First, Middle,	16b. Kir	Specify: Whi	ndustry
Maryland	Mental Mental arked o	To Be	Carmello Lupis						Chia	rina	Vetran	.0		
	and 2 sho salth and n 27 Is m		19a. Informant's Name/Relationship ( Carmine Valente/s				ng Address Rams			ar or Rura Ann	apolis,	r, City or MD	70wn, State, 2 21403	ip Code)
Baltimore,	Pages 1 ament of He ent: If item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ remation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specification)	1)	Metro	tery, crei Cre		her place Y	1	./9/2	2007	Cato	ation - City or onsville	e, MD
Ball	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licer	Radder	01442	4	112 0	ld C	olumb	oia F	k. Ell	icot		1y FH Inc. MD 21043
	Physician /Medical		23a. Part 1 Finter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	od the death. Diline.	ent	er the mode	He.	, such as	_	ir respiratory arr	est,		Approximate Interval Between Onset and Death 3 DAYS
8760,	cate be executed by sician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to finite diatacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence		en	w	<u> </u>					gean
.O. Box 6	the death certifi y the attending i ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 21 No 9 □ Unknow		e of pregnancy 2  Fetal dea at time of death		Ectopic pre					23	3d. Date of deli Month	very Day Year
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of	ng Physician: The la fler this certificate has uneral director, page 2	To Be	25. Was case referred to medical examiner?  1 Yes 2 Vo  27. Manner of Death  1 Vatural 5 Pending	Hospital: 1 Inpat	ury 28b	Outpatien  Time of Injury		Othe	r: 4 🗆 Nur	rsing Hor	(Check only on ne 5  Reside 28d. Describe ho	ence 6	A Other (Spec occurred	(F)
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ertification:	2 Accident investigation 3 Suicide 6 Could not by determined	28e. Place of Ir	ijury - At home, tc. (Specify)	farm, str	eet, factory,		es 2□N	-	28f. Location (St. City or Town	reet and n, State)	Number or Rui	al Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	edical Co	29a. Certifier (Check only one)  Certifying Ph 2 Medical Exam	ysician: To the bes liner: On the basis and manners	of examination a	lge, death and/or inv	occurred a vestigation,	it the time	e, date and inion, deat	d place, a	and due to the ca	ause(s) a ate and p	and manner as place, and due	stated. o the cause(s)
1		Me	29b. Signature and title of certifier	- 2P	2mta	m	29c.	License	number	<b>R14</b>	₹.	9d. Date	signed (Month)	Day, Year)
ì	E.3>	4	30. Name and address of person who	completed cause of	death (Itom 23a	Type,	Print) JSE	Ans	HWI	In 1	ANNA	POLIS	MOL	140)
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			1 - For State Registrar	State of Maryl	and / Depa	artment of Health and rtificate of Death		ene 0 0 7	01669
			Decedent's Name (First, Middle, Last)	)			2. Date of Death		3. Time of Death
	Physic		Melvin Oakley Wa	alker			January	Day Year 9 2007	18:48PM
1	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Deat		4c. County of Death	10:40FM
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	Funeral		5. Social Security Number 6. Set	7. Age (In )	rs. last birthday)	II Under Hage Ti Onder 24 Hrs		<del></del>	ace (State or Foreign
ы	Director		541–18–7939	M 2□F 9	2 Yrs.	Months Days Hours Min.		1914 Orego	
	p ,		Usual Residence of Decedent					To To Tog	JII.
	anyla ehov	-	10a. State   10b. County     Maryland Washin		City, Town or Lo			10	Od. Inside City Limits
	8a-f	Funeral Director		igcon	Hagers	COMI			1 ☐ Yes 2 No
	or 2	Dire	10e. Street and Number	_		10f. Zip Code	100	g. Citizen ol What Coun	try?
	ath v	<u>a</u>	14104 Wm.Talcott			21742		U.S.A.	
	tem de	nue		12. Was Decedent Ever in Amed Forces?	n U.S. 13. 1	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	an Indian,
36	orl	Ž.	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give	1	1 ☐ Yes 2 No Specify:	,		
8	hour ural	D D	3 Widowed 4 Divorced	Year or Dates:				Specify: Whit	ce
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2	withii then	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)		ssembly		D1- M1	M.C
2	tiled within 72 hours after death with the Maryland Hygiene. uther then "natural", or terms 23s or 28s-f show ant, the Medical Exacting must be notified at	ŏ	17. Father's Name (First, Middle, Last)		Λ		ne (First, Middle, Ma	Drink Mach	ine Mrg.
an	ntal od be	Be	Reuben Walker				ine Foney	iiden Sumame)	
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Maryland 21215-0036	d 2 s th an t7 te		3 32			g Address (Street and Number or Ru			
Ġ,	Heel Heel		Gaynell Walker (wi	fe)  20t	14104 D. Place of Dispo	Wm. Talcett Lane sition (Name of natory or other place)	Hagersto	wn Maryland	21742
Baltimore,	nt of nt of t: If it		1 Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cren	natory or other place)	2.0007	T.	vii, State
틀	rtani njun		4 ☐ Donation 5 ☐ Other (Specify)  21 Signature of Funeral Service License			en Cemetery 1-1	2-2007	Hagerstown	Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itema 23a or 28a-f show way figury or other traumatic event, the Medical Examination must be notified at anote.		21 Signature of Porteral Service License	Z	22	. Name and Address of Facility Do	ouglas A.	Fiery Funer	al Home
			23a. Part1. Enter the disease, or compli	XMY		<u> 1331 Eastern Blyc</u>	l. N. Hage	rstown Mary	<u>land 21742</u>
			snock, or near/failure. List only on	e cause on each line.	`	1	or respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Farkins	OKS	disease			Criser and Death
	Examiner			Due to (or as a cons	sequence of):				
		<u>.</u>	Sequentially list conditions, b	. Due to (or as a cons	and the same of				
	sit	uju	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	вециенсь оп.				
	and and Il-trar	Examiner	that initiated events cresulting in death) Last	Due to (or as a cons	sequence of):				
8760,	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit			(0, 20 2 30)					
387	icate phys s the	dicai	d					100	
×	leath certific attending p	/Me	IF FEMALE:	3c. If yes, outcome of preg	nancy			1	
Вох	atten for u	ian	in the past 12 months?	1☐Live birth 2☐F	etal death 3	Ectopic pregnancy		23d. Date of deliver	y Day Year
o	at the de by the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time o 9☐Unknown	rdeatn 5⊔	Other (specify)			
مـ	res that tigned by	된	Part II. Other significant conditions con	tributing to death but not r	esulting in the un	deriving cause given in Part I	23e Did tohac	co use contribute to the	cause of death?
Records,	sign d be	d by	hunestersia c	LIENI M	- Zuch	vie Auli- au	1 ☐ Yes		bly 4 Unknown
Š	w require been si should b	Completed	1.	1		- Francisco	163		ory 4 Donkhown
ĕ	: The law cate has page 2 s	d E	Ciserse, anemia	- Mypotey	K31D	peptic ulun	24a. Was an autopsy	prior to com	sy findings available pletion of cause of
			cisease, dysp	nagia			performed		!□ No
Vital	Attending Physician: The death. setor: After this certificate by the funeral director, page	Be	25. Was case referred to medical examiner?	ospital:			th (Check only one)		
5	Phys this aldii	2	1 Yes No	1 ☐ Inpatient 2	☐ ER/Outpatient			e 6 □Other (Specify)	
5	ding l	5	Natural 5 Pending	28a. Date ol Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
Division of	if or Attendi after death. I Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be	20 - Plane of Jainey As		M 1 Yes 2 No			
=	5 g t g c	팊	4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	city)	et, factory, office	City or Town, S	et and Number or Rural i State)	Route Number,
	Hospital or 14 hours afte Funerel Dit tely filled in		29a. Certifier Certifying Physi	ician: To the best of my le					
	24 hr 24 hr Fun etely	Medical	(Check only 2 Medical Examin	er: On the basis of exami and manner stated.	nation and/or inv	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as state and place, and due to t	ed. he cause(s)
	To the Hospital within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title of certifier	January Stated.		29c. License number	204	Date signed (Month, Di	av Year)
	- 5 - 0		11/8	10		D46940		01-11-20	
			30. Name and address of person we con	nnleted course of death (*)	om 22+1/T : =				
			LS. E. Kest Z.e. C. M	2011	ern zoa) (Type, P	Ivania Avenue H	Lacert	MD 1	174)
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	Ivonia Avenue 19	2000	~ 1 . 5	1-10
100	Registr		14 N T O 201	17	M. An	erked			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 0505 Mildred Virginia Neal Webster Jan. 02 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Wicomico Peninsula Regional Medical Center Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State March 7, 1918 Mary Land 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1 □ M 2 1 214-07-9714 88 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b, County show r 28a-f show notified at 1 TYes 2 No Director Dorchester Cambridge Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be **USA** 21613 1A Shady Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 PNo Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11 College (1-4or 5+) State Health Government Occupational Therapist permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; If Item 27 is marked other the amy Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Willey Rex W. Neal, Sr. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6451 Leslie Lane, Laurel, DE 19956 19a. Informant's Name/Relationship (Type. Print) 6451 Leslie Lane, Laurel, DE Shirley P. Burton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 1/9/2007 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses Curran-Bromwell Funeral 308 High St., Cambridge, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sentreemia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SCIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 TYes 11 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of ce

31. Date filed (Month, Day, Year)

30. Name and add

DHMH 17 Rev 1/2001

E. Carrell Si

s of person who completed cause of death (Item 23a) (Type, Print)

2007

100 32. Registrar's Signature 0

11.7	1	For State Registrar  1. Decedent's Name (First, M.	ddle Lasti		Marylar	-	artmen rtificat			and M	lental Hyo	Reg. N62 0	07	0   6 7 2
Physicia	n	Richard	Lee	Ward							Month	Day	Year 07	10:00 P
/Medica Examine		la. Facility Name (If not institu					4b. City,	Town, or	Location o	of Death		4c. Cour	nty of Deat	
Examine		30 Foxy Cour	t				Ris	ing	Sun			C	ecil	
Funeral		S. Social Security Number	6. Sex	x 7.	Age (In yrs.	last birthday)	If Under Months		If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Da)	h		hplace (State or Foreignetry)
Director		222-18-1970		MM ZUP		71 Yrs.					May 20			lax, VA
and w	-	Usual Residence of Decedent  10a. State 10b. Cou			10c. C	ity, Town or Lo	cation							10d, Inside City Limit
Mary -f eh	ō	MD Ce	cil		D.	ising S	***							1 ☐ Yes 2 🗷 N
h the Marylan r 28a-1 show	Director	10e. Street and Number	CII		, K	rerng 2	10f. Zip	Code				10g. Citizen o	of What Co	untry?
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<u>ĕ</u> ≝ ∰ .	by Funeral	I1. Marital Status  1 ☐ Never Married 2 ☐ N  31 ☑ Widowed 4 ☐ Divor	farned	12. Was Decedor Armed Force 1  Yes 2 If Yes, Give Year or Date	es? <b>X</b> No		Was Decect f Yes, spec 1 ☐ Yes		spanic Orion, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. R B	lack, White	ncan Indian, a, etc. white
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be filed trat Hygie d other event, tr	99	17. Father's Name (First, Mide	lle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Sum	a <i>m</i> e)	
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is 1 and in Health item 27 other tre	- 1-	Tracy Lander 20a. Method of Disposition	(dau	ghter)	20h						Sun, M			F Chat.
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The law ate hes b	Completed										24a. Was a autop perfor	sv	o. Were autoprior to death?	topsy findings available ompletion of cause of
sicien: Th certificate irector, pag	ן מ	25. Was case referred to med examiner?	-	lospital:				1 00		of Death	(Check only or	ne)		
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he Hospi n 24 hou he Funes pletely fil	ealcai	29a. Certifier 1 Certi (Check only 2 Medione)	ying Phys	sician: To the be ner: On the basi and manner	s of examina	owledge, death ation and/or inv	occurred a	at the tim in my op	e, date and inion, deat	d place, a	and due to the dead at the time, o	ause(s) and r date and place	manner as e, and due	stated. to the cause(s)
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			For State Registrar		State of M	aryland	d / Depa	artment rtificate	of H	ealth a Death	nd Me		iene		01673
	Physici	an	1. Decedent's Name (i	First, Middle, Last								<ol><li>Date of Deat Month</li></ol>	Day	y Year	3. Time of Death
	/Medic		GEORG	E	J. W	HITE						JANUARY			9:10 A M
12	Examir	er	4a. Facility Name (If no			}				Location of				County of Dea	
		29	4005 TERR			no (la ura la	est hirthday			MARLB If Under 2		Date of Birth			GEORGE 'S
*	Funeral Director		5. Social Security Num  101–18–23  Usual Residence of December 19	38	X XM 2□F	82	Yrs.		Days	Hours	Min.	B. Date of Birth (Month, Day, SEPT 5	Year)		thplace (State or Foreign ountry) YORK
	/land		10a. State 1	0b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Man,	to	MD :	PRINCE G	EORGE 'S	UPPE	R MAR	LBORO							1 X Yes 2 ☐ No
	r 28	Director	10e. Street and Numb	er				10f. Zip	Code			1	0g. Cit	izen of What Co	ountry?
	23a c		4005 TERR	YTOWN CO	URT				2	0772			ι	J.S.A.	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural" or Iteme 23s or 28s-f show event, I're Medical Everthear must be routhed at	by Funerai	11. Marital Status  1 Never Married  3 Widowed 4	12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No <b>Army</b> If Yes, Give Year or Dates:			Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica     □ Yes 2 XNo Specify:				Rican, etc.) Black, W		14. Race - Ame Black, Whit Specify: BL		
ŏ	2 hou			5. Decedent's Edi			16a. Dece	dent's Usua	f Occupa	ation			16b. K	ind of Business	/Industry
Maryland 21215-0036	within 72 liene. then "nat	Completed	(Specify Elementary/Second	only highest grad arv (0-12)	Coflege (1-4or	5+)	life.	kind of wor DO NOT us	e retired,	) )	or working				
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ita	nysician: Th is certificete director, pag	Bec	25. Was case referred examiner?	-						26. Place	of Death	Check only on			
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Division of	Attending Physician: r death. sctor; After this certific by the funeral director, I		27. Manner of Death 1 X Natural 2 ☐ Accident	28a. Date of Injury (Month, Day Year) 28b. Time of Injury			of 28c. Injury at Work?  M 1 Yes 2 No			28d. Describe how injury occurred					
DIVIS		Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined  5 ☐ Could not be determined  5 ☐ Could not be determined  6 ☐ Could not be determined  6 ☐ Could not be determined  7 ☐ Street and Number or Rundle City or Town, State)									ural Route Number,			
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	The same		30. Name and addres	s of person who o	ompleted cause of	death (Item	23a) (Type,	Print)	\$	Foi	two	ash,	91	w Kn	020744,

Registrar

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	Physici /Medi		1001010 1111011 111110110									
	Examir		4a. Facility Name (If not institution, Anne Arundel Me	dical Center		An	Location of Death		4c. County of Deal	rundel		
3	Funeral Director		5. Social Security Number 213–34–7538  Usual Residence of Decedent	S. Sex 7. Age	(In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 3,	9. Bin 1937	hplace (State or Foreign ountry) Maryland		
	Maryland	tor	10a. State 10b. County	Annes	10c. City, Town or Le		ensville		10d. Inside City Limits 1 Yes 2500			
	th with the 23a or 284	Funeral Director	10e. Street and Number 200 Terrapin Gr	ove, #105		10f. Zip Code	21666	1	Og. Citizen of What Co			
980	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic event, its Medical Examinar mast ke notified at	þ	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 XDivorced	12. Was Decedent E Armed Forces? d INXYes 2 No If Yes, Give Year or Dates: 1	0	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: V			
21215-0036	s within 72 ho piene. r than *natur the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	(Give	dent's Usual Occupa kind of work done of DO NOT use retired, —employed	16b. Kind of Business Floor cove	d of Business/Industry					
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than "raumatic event, it a Men	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's					e (First, Middle, Maiden Sumame) 1 E. Jacobs				
	1 and 2 sho Health and I em 27 is ma		19a. Informant's Name/Relationshi		2715	Snowbird '	Terrace,	#2, Silv	City or Town, State, 2 Ver Spring,	MD 20906		
Baltimore,	permit. Pages 1 ar Depertment of Hea Important: if item : any injury or other page.		20a. Method of Disposition 1 ☐ Burial 2220 cremation 3 4 ☐ Donation 5 ☐ Other (Spe	icify)	Ft. Linc	matory or other place oln Crema	*) tory 1/3/	′2007 I	Brentwood,	Maryland		
Bal	Depermination of the control of the		21. Signature of Fareral Service 21.  23a. Part1. Enter the disease, or or	E Ru	le 1	47 Duke o	f Glouces	ster St.,		Approximate		
8760,	Physician /Medical Examiner physician and physician and physician site physician in the principle of the physician p	Ilcal Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c.	θ.	ruc true				Interval Between Onset and Death		
.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal death 3[	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year		
rds, P	w requires that been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							the cause of death?		
tal Records,	ician: The law re certificate has bev rector, page 2 sho	e Completed	25. Was case referred to medical	br.			00 Blv - 4 D4		y prior to death? 1 ■ Yes	topsy findings available completion of cause of		
Division of Vital	uttending Physician: death. ctor: After this certific y the funeral director,	Certification; To B	examiner?  1 Yes 2 Yo  27. Manner of Death  1 Natural 5 Pending 2 Accident investiga 3 Surcide 6 Could no	t be 200 Blace of Isius	Year) 28b. Time o	f 28c, injury Work M 1 \( \)	4 LI NUISING HO	me 5 Reside 28d. Describe ho	once 6 Other (Special or injury occurred			
Div	or A		4 Homicide determin	building, etc.  Physician: To the best of			e data ar triaca	City or Town				
	To the Hospitel within 24 hours of To the Funerel completely filled	Medical	(Check only 2 Medical Exone)  29b. Signature and title of certifier	caminer: On the basis of and manner stat	examination and/or in	vestigation, in my op	inion, death occur	red at the time, da	ate and place, and due	to the cause(s)		
	541)		30. Name and address of person w	ho completed cause of de	ath (Item 23a) (Type,	D3 Print) 2001 N	7804 Medical P	arkway	1-1-200	7		
No.	Sta Registi		31. Date filed (Month, Day, Year)	N 0 4 2007	und	AAM	c 1	Lunigel	ls Mis	21401		

			For State Registrar	State o	of Maryland		artment of H			giene Reg. No.	007	01675	
			1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of Death	
Physician /Medical Joseph E. Williams, Sr.									Januar	Day	Day Year 2 2007 9:13 P M		
	Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of De			County of Dea		
			St. Thomas More	Nursing	& Rehab.	Ctr	. Hv	attsvil	1e		Princ	e George's	
	Funeral			S. Sex	7. Age (In yrs. last		If Under 1 Year	If Under 24 H	s. 8. Date of Bir	th Voar		thplace (State or Foreign ountry)	
	Director		579-50-5263	1 <b>X</b> □M 2□F	66	Yrs.	Months Days	nouis Mi	Mar. 1			sh. DC	
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 Cit. T							-	
	anyla shov	-	Toa. State		10c. City, T	OWII OF LO	cation					10d. Inside City Limits	
	Ba-f	ecto	DC					Washing	ton			1 XYes 2 No	
	vith t	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	ountry?	
	s 23s	Funeral	203 N St.,					20024				States	
	er de ftam	nu	11. Marital Status	Armed Fo		13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? n, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	- 1	<ol> <li>Race - Ame Black, White</li> </ol>	te, etc.	
36	rs aft	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ☐ Yes If Yes, Gir Year or □	ve		I□Yes 2/□No	Specify:			Specify:	frican	
8	hou	edit	15. Decedent's			6a Docor	ient's Usual Occupa	tion		10h Via	And of Business	merican	
5	in 72 n "n	Completed	(Specify only highest	grade completed)		(Give	kind of work done d DO NOT use retired)	uring most of w	orking	100. Kill	id of Business	maustry	
21215-0036	iene.	E O	Elementary/Secondary (0-12) 12th	College (	1-4or 5+)		Cab Dr				Т	rivate	
ō	Hyg other ant,	Be C	17. Father's Name (First, Middle, La	ast)					ame (First, Middle,	Maiden S		IIVale	
au	ld be ental kad ic av	To B	Alvin W	illiams					Ida S	immor	15		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mental Hygiene.  If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic avant, the Medical Examinar must be notified at	-	19a. Informant's Name/Relationship	p (Type, Print)	1	9b. Mailir	g Address (Street a	nd Number or I				Zip Code)	
	nd 2 aith a 27 is		Deborah Willia	ms/Snous	0		203 N St	CU #	424, Was	h T	C 200	24	
ē,	s 1 a f Hei f Hei itam othe		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place		Date Date	20c. Loc	cation - City or		
Ë	Page ent o nt: ff ry or		1 XBurial 2 ☐ Cremation 3  1 4 ☐ Donation 5 ☐ Other (Spe		State	-	t Cemeter	. 1	1/2007	T,	Vash.,	DC	
altimore,	permit. Pages 1 and 2 Department of Health a Important: if itam 27 is any injury or other tra		21. Signal re of Funeral Service Li		0 - /		. Name and Addres		Stewart				
ď	Depai Impo any ir		I John T.	Denter	TIT T	61	4001	Benning	Rd., NE				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate										
	Physician		shock or heart failure. List only one cause on each line. Immediate wuse (Final										
	/Medical Examiner		disease or condition resulting in death)		yocardial		arction					1 Hour	
Н			Sequentially list conditions b. Coronary Artery Disease									V	
		je.	Sequentially list conditions, if any, leading to immediate		Due to (or as a consequence of):							Years	
	outed id ansit	E I	Cause (Disease or injury that initiated events	c									
oʻ	an ar rial-t	EX	resulting in death) Last	Due to	(or as a consequent	ce of):							
8760,	ficate be executed physician and s the burial-transit	dicai Examiner		d									
9	ng ph as tl		IF FEMALE:							-			
Вох	eath certific attending p for use as	an/l	23b. Was decedent pregnant		tcome of pregnancy pirth 2 Petal dea		Ectopic pregnancy			23	3d. Date of del		
Ш	ed fo	sici	in the past 12 months? 1 Yes 2 No		nant at time of death		Other (specify)				Month	Day Year	
P.O.	The law requires that the death certificate has been signed by the attending I has been signed by the attending I hage 2 should be detached for use as	Physician/Me	9 Unknown								_		
	res tha igned be det	by	Part II. Other significant condition	s contributing to d	eath but not resultin	g in the ur	nderlying cause give	n in Part I.				the cause of death?	
or c	w requir been si should	ted							1 🗆 \	/es 2 □	]No 3 ☐ Pr	obably 42\textsup Unknown	
Records,	e law r has be je 2 sh	Completed							24a. Was		24b. Were au	itopsy findings available completion of cause of	
		Con							perfo	rmed? 2 XNo	death? 1 ☐ Yes	2 No	
Vital	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					26. Place of De	ath (Check only o				
	S D	2	1 ☐ Yes 2 █No	Hospital: 1	Inpatient 2□ER/	Outpatien	t 3 DOA Othe	r: 4X Nursing	Home 5 ☐ Resid	lence 6	□Other (Spec	city)	
ב		on:	27. Manner of Death 1   Natural 5   Pending	28a. Date (Mon	of Injury 28t th, Day Year)	b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	now injury	occurred		
<u>S</u>	Attending r death. actor: After by the fune	cati	2 ☐ Accident investiga					es 2 □ No					
Division of	l or Attendation after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 288. Place	of Injury - At home, ng, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and m, State)	Number or Ru	ıral Route Number,	
	ospital of hours all unarel D								1				
	T 4 T 0	edical	29a. Certifier 1 Certifying (Check only one) 2 Madical Ex	arminer: On the b	best of my knowled asis of examination	dge, death and/or inv	occurred at the time restigation, in my opi	e, date and plac inion, death occ	e, and due to the curred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
	To the Within 2 To the comple	Med	29b. Signature and title of certifier	and man	ner stated.		29c. License				signed (Montl		
	1/1		N. P.	0,				019609					
	(2)		30. Name and address of person wh	no completed servi	of death /line co.	a) (Turn 1		712003		Jan	uary 7	<b>,</b> ∠007	
	AC.		Raman R. Tuli				,	D M=	Doint	MI	20710		
	Sta	te	31. Date filed (Month, Day, Year)		3503 Perri egistrar's Signature		, bulle	D., ME.	rainier,	TID	20712		
	Registr		JAN 0 9 2007	baren !	O. Sound	N	*						

			1 - For State Registrar	State of M	arylan		artment rtificate			and M		giene Reg. No. ()	)7	01676	
ž	Physici	an	Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent's Name (First, Middle, La.      OARDER      Decedent (First, Middle, La.      OARDER      Decedent (First, Middle, La.      OARDER      Decedent (First, Middle, La.      Decedent (First, Middle, Middle, La.      Decedent (First, Middle, M								2. Date of Dea Month	ith Day	Year	3. Time of Death	
	/Medic	al		REE SPIVE		LLIAMS		-		15	January			10:05 P. <sup>M</sup>	
-	Examin	er	4a. Facility Name (If not institution, given St. Thomas More						Location o				y of Death	eorges	
	Funeral		Rehabilitition  5. Social Security Number 6. S		ge (In yrs.	ast birthday)	If Under		If Under		8. Date of Birtl	1		nplace (State or Foreign	
¥.	Director		242-42-4043	1□ M 2 <b>X</b> F	81	Yrs.	Months	Days	Hours	Min.	July 1	, Year) 5.1925	Cor	th Carolina	
	D ,		Usual Residence of Decedent  10a. State 10b. County		1.0.0										
	shov	5				y, Town or Lo								10d. Inside City Limits  1X Yes 2 □ No	
	the M	Director	Maryland Prince  10e. Street and Number	Georges		Hyatts		Ond-				10g. Citizen of	110		
	with a or		4922 LaSalle Roa	.a			10f. Zip		00			3		,	
	72 hours after death with the Maryland haturel', or Items 23e or 28e-f show alsoil Exant art must be trailled at	Funeral	11. Marital Status	12. Was Decedent		S. 13.1	Was Decede	207 ent of His		gin? (Spe	city Yes or No- Rican, etc.)	Unite		ates rican Indian,	
9	or Ite	표	1 Never Married 2 Married	Armed Forces						, Puerto I	Rican, etc.)		ack, White		
93	eurs Ers	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2	A NO	Ѕреспу:			Speci	ly: B	lack	
5-(	72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usual kind of worl	k done di	urina most	t of workir	ng	16b. Kind of E	Jusiness/I	ndustry	
12	withir ane. then	d I	Elementary/Secondary (0-12) <b>7th grade</b>	College (1-4or	5+)		DO NOTuse mesti					т.			
р 5	Hygie Hygie other		17. Father's Name (First, Middle, Last)	)		ВО	шеѕст			r's Name	(First, Middle,		omest	LIC	
<u>a</u>	id be iental ked c	To Be	Curry Flower						Anr	_	Spive		,		
ary	shou and M and M mar	-	19a. Informant's Name/Relationship (	Type, Print) (Daus	ghter	19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura			, State, Z	ip Code)20009	
Σ	and 2 saith n 27 i		Gladys Mae Spivey	-		-1					;Apt.90				
ore	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. P	lace of Dispo emetery, crer	sition (Nami natory or off	e of ner place	) T		,2007	20c. Location	- City or T	Fown, State	
Ë	Pag tment tant: lury c		4 □ Donation 5 □ Other (Specify	y)	Re	st Hav			ry		V	Vilson,	Nortl	h Carolina	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "nature!, or items 23s or 28s-f show eny injury or other traumatic event, "Its Medical Exam er must be invitible at 20c.		21 Signature of Funeral Service Licer	BA	rto	6	UU Kei	nned	y Str	ceet,		ıshingt	Inc.	.c. 20011	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that cause one cause on each li	d the death ine.	n. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory ari	est,		Approximate Interval Between	
			Immediate Cause (Final disease or condition resulting in death)  a. Atheroselerobic Cardiovasculor disease											Onset and Death	
			Tooling in double,	Due to (or as a consequence of):  Demenha											
		e.	Sequentially list conditions, if any, leading to immediate	b Due to (or as	b. Due to (or as a consequence of):										
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
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8760,	cate be executed physician and the burial-transit	Physician/Medical	•	d											
9	entific ling p	Med	IF FEMALE:												
Вох	res that the death certificing by the attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pre						ate of deliver	very Day Year	
P.O.	the de	yslo	1 ☐ Yes 2 🙀 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	aun bi	Other (spe	спу)							
	that ned by deta		Part II. Other significant conditions of	contributing to death b	out not resu	ulting in the u	nderlying car	use giver	n in Part I.		23e. Did to	bacco use con	tribute to	the cause of death?	
rds	quires n sign	ed by									1 🗆 Y	es 2 🗶 No	3 Pro	bably 4 Unknown	
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Ž	hysic this o	2	1 ☐ Yes 2 X No			ER/Outpatien		Other	r: 4 🗶 Nur	rsing Hon	ne 5 Resid	ence 6 □Otl	ner (Speci	ify)	
Z	Jing F After funer	lon	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		c. Injury			8d. Describe h	ow injury occur	red	3	
Division of Vital Records,	Attending Physician: The law requires that the r death. r death. ector: After this certificete has been signed by the type funeral director, page 2 should be detached the funeral director.	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	θ Ogo Diogo of Inc	iury - At ho	me farm str	M factory		es 2 N		8f Location (S	treet and Num	her or Ru	ral Route Number,	
<u>S</u>	after Dire d in b	Certification:	4 Homicide determined	building, et			sot, raciory,	Onioe		-	City or Tow	n. State)	767 01 7101	ar House Northber,	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 X Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examinat	wledge, death tion and/or inv	occurred a restigation, i	t the time	e, date and inion, deat	d place, a h occurre	nd due to the cod at the time, d	ause(s) and m ate and place,	anner as	stated. to the cause(s)	
	To the within 2. To the I complete	Me	29b. Signature and title of certifier				29c.	Licens <i>e</i>	number		2	9d. Date signe	ed (Month	. Dey, Year)	
)	10			MD			D	00	601	00	J	anuary	4th	, 2007	
	5		30. Name and address of person who	completed cause of c	leath (Item	23а) (Туре,	Print) 83	31,	Univ	ress ve	1 Si.	d Say	L . Su	is no 27	
			TAHMINA KA	HMED.	Silv	us SP	mf,	MC	) 2	090	3 .			•	
	Sta Registr		JAN 0 9 2007	32. Registr											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1, perMD, State of Maryland / Department of Health and Mental Hygiene 0 0 7 1 - For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Leo Burroughs, Sr. 3. Time of Death Month Year **Physician** January 1945 15 7.007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Ol 31 20 Augsburg Lutheran Nursing Home N/A Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 219-05-0706 Yrs MD **Director** 86 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumstic event, the Medical Exercities must be multipled at 1 XYes 2 ☐ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 2020 Featherbed Lane Apt 318 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Kovans Clothing Sales Person 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental Hitem 27 is marked off Be Mary E. Gurry ပ္ Eli Burroughs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type, Print) 2020 Featherbed Lane Apt 318, Balto, Mary D. Burroughs-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department o Importent: If any injury or once. King Memorial Park 1/20/07 Randallstown, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Ulcensee 21215 Approximate Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition ASCUD Physician eavs resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner I Records, P.O. Box 68760, E burial-trans and Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗌 No 3 ☐ Probably 4- ∰Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 Yes 25 No or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4- Nursing Home 5 Residence 6 Other (Specify) ို 1 🗌 Yes 2₽ No 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ D37573 16,2007 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reistertan 22 54. MD 7. bell Main 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4

DHMH 17 Rev 1/2001

Registrar

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend #19b, perFh, g863, 1/24/07 TT Certificate of Death

Registrar

Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Veal **Physician** James Brooks ANUATU 15 Z007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UNIVERSITU BRETIMORE pecialiti If Under 1 Year | If Under 24 Hrs. 5. Social Security Number ge (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F Director 218-42-6688 62 07 07 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director X□Yes 2□No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t Funeral 817 West Saratoga Street 21201 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2√ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Black þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 7th grade Construction Worker Construction Co. na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 Is marked ott ပ John R. Brooks Harriette Lunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Roland Brooks-Brother 5124 Sekots Road, Baltimore, Md 2120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town State Department of Important: If It any Injury or o 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 1/23/07 Baltimore, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heint Direvse **Physician** Ischemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ricomo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed DITLOTAL Stoge burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nertunion Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 JUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1∐ Yes 2 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 952749 01-16-07 I ATAM HIRPINAN MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunth 601 Bortmone, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

BROOKS,

1. Decedent's Name (First, Middle, Last)

Maryland 21215-0036

INTOR.

Ö Records, of Vital

**Physician** Month 28 2ď07 6:20 PM Levater Brooks /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4b. City, rom...

Catonsville

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

O5 07 21 Baltimore Summitt Park Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 85 Yrs. Director 216-16-5867 MD Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23s or 28s-f show shy Injury or other freumatic avent, If a Medical Examiner must be prefitted at once. Y☐ Yes 2 ☐ No Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1617 North\_Dukeland Street 21216 U.S.A. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 X No Specify: δ Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Machine Operator Diageo NA Global na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oregan Brooks Mary Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarawak Fultzer-Nephew 3820 Penhurst Ave, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Calvary 1/24/07 Brooklyn, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Adult Fallure to **Physician** /Medical Due to (or as a consequence of) 2 montain Examiner ascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physicien and die detached for use as the burial-transit Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II\_Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown should postive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ✓ o 24a Was an hes Kidney 1 ☐ Yes 2 D No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Yes 2 No Other: 4 Wursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier H45931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7220 PARK HEIGHTS AVENUE BALTIMORE MO Eborah I 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 2 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2 Date of Death

3. Time of Death

		For Amend Item State of Maryland Dep. State Registrar	artment of Health and N 01/24/0/dhb rtificate of Death	lental Hygid Reg	ene 1. No. 2 () () 7 () [680						
Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year 7:15 a M						
/Medic Examin	al	BRENDA J. BRASWELL  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JAN	7 2007 7:15 a M						
LXaiiiii	CI	ANNE ARUNDEL HOSPITAL	ANNAPOLIS		ANNE ARUNDEL						
Funeral Director		5. Social Security Number  237-74-2731    6. Sex	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, ) Mar. 14,	(ear) 9. Birthplace (State or Foreign Country) 1948 North Carolina						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hydiene. Important: If them 21 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	al Director	MD         Prince Georges         Temple H           10e. Street and Number         3009 Southern Ave Unit 11		100	10d. Inside City Limits 1 □ Yes 2 ☒ No g. Citizen of What Country? USA						
nours after deal	d by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.  Specify: Black						
d within 72 h giene. er than "nati	Completed	(Specify only highest grade completed) (Give life.  Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Tou:	dent's Usual Occupation  kind of work done during most of work  DO NOT use retired)  r Guide	ding	Self Employed						
ld be file ental Hy ked oth Ic event	To Be	17. Father's Name (First, Middle, Last) Wilbert Braswell	e (First, Middle, Ma se Coore	aiden Surname)							
nd 2 shou alth and M 27 is mar	-	3009	City or Town, State, Zip Code)								
ages 1 a and of the first of the front of th		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetery, cre	matory or other place)	Date 20	Oc. Location - City or Town, State						
permit. P. Departme Important any injury once.			metery 1-13 2 Name and Address of Facility Marshall's Funeral 4217 9th St. N.W.	Home, In							
Physician /Medical Examiner  (the prival-transit	dical Examiner	23a. Palf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):									
The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as the	hysician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year						
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ysicial ysicial is certi	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Othor	th <i>(Check only one)</i> ome	ce 6 □Other (Specify)						
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: T	27. Manner of Death  1 Notural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how							
To the Hospital or Attending R within 24 hours after death: To the Funeral Director: After completely filled in by the funer.	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)						
he Hospii n 24 hour he Funer pletely IIII	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dear medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as stated. It is and place, and due to the cause(s)						
To t Withi To t	M	29b. Signature and title of certifier  Michael Pritale May	29c. License number 1700211	j 9 290	d. Date signed (Month, Day, Year)						
Ф		30. Name and address of person who completed cause of death (Item 23a) (Type, MICHCAIC PISTOCE MIN 211	Print) 2 = S+ SULL	603 Wa	d DC 20037						
Sta Registi		31. Date filed (Month, Day, Year)  JAN 2 4 2007  32. Registrar's Signature									

07-00583	
Lorraine Boswell	

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Physici Medical Exami	an/	Decedent's Name (First, Middle,Last)		-		2. Date of Deat Month January 2	h	3. Time of Death 0810 hrs				
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		Sinai Hospital		Baltimo		##						
Funeral Director		219-32-2066 1 M 2 XF	74	birthday) If Under Months  Yrs.	1 Year If Under 2 Days Hours	Min. 10/07/	th(MM/DD/YYYY) 9. Bird Foreig Cor	n Maryland untry)				
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ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number		10f. Zip C		10	og. Citizen of What Cour	ntry?				
with the ms 23a be noti		3108 Virginia Avenue  11. Marital Status  12. Was Decedent E	ver in US.			(Specify Yes or No-		can Indian, Black,				
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Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic	ı	20a. Method of Disposition		ce of Disposition (Name matory or other place)	of cemetery,	Date Date	ore, Maryla 20c. Location - City or	Town, State				
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other Specify:	·	ro Cremator	y Inc. 01	/24/2007	Baltimore,	Maryland				
Balt permit Depart Impor injury		21 Signature of Funeral Service Licensee					k C. Jones					
Physician		28a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each top	e death. Do	not enter the mode of	rk Hgts. dying, such as card	AVE., Balliac or respiratory arre	C.LMOTE, Mar est, shock, or heart	yland 21215 Approximate Interval Between Onset and				
/Medical Examiner		Immediate Cause (Final disease a. Hypoxic end	ephalo	pathy				Death				
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Box 687 death certific the attending p	ician	past 12 months?  Pregnant at tir	me of death	2 Fetal death  5 Other (Specif	3 Ectopic pr	regnancy	Month D	lay Year				
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ion ttendin leath tor: A	atior	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year	ir)		1 Yes 2 N	0						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be 28e. Place of Inju	ry - At home	e, farm, street, factory, o	office building, etc.	28f. Location (S or Town, S	Street and Number or Ru tate)	ral Route Number, City				
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To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated  29b. Signature and title of certifier	nation and/		ppinion, death occur	red at the time, date						
· V	-	Carol Laco	die		O.C.M.E.		29d. Date signed (Mor January 22, 2007					
14 me		30. Name and address of person who completed cause of dea					L					
1 1/2	-01-	Carol Allan, MD Assistant Medical Exami  31. Date filed (Month, Day, Year) 32 Registrar's		11 Penn Street, B.	altimore, MD 2	1201						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 22 2007 Year **Physician** 10:24 A M January Henry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford County <u>Upper Chesapeake Medical Center</u> Bel Air If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F W. Virginia Feb.08 Director 214-56-4096 Usual Residence of Decedent 54 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Aberdeen Harford County Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21001 Completed by Funeral 255 Graceford Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 → No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. spewhite 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Belvedere Hotel Electrican 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruby George Η. Brown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important; If Item 27 is any injury or other trau 255 Graceford Drive, Aberdeen, Md. 21001 (Brother) Jimmy R. Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Meadowridge Memorial Pk.1/25/07 Elkridge, Md. 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee m00922 130 E. Fort Ave. Baltimore, Md. 21230 23a. Part1. Enter the disease, or com shock, of healt failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lst only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician trosepsis /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit and Due to (or as a consequence of): Brown Henry M 500 430 793 Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown certificate has been signed by irrector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1□ Yes 2♥ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 27 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 ☐ Accident 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D34652 MD 30. Name and address of person who completed cause orgical (Item 23a) (Type, Print)

Scott Huswill & North Avinus Bil Air Maryland 21014 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month

McGintey MD, 500

32 Registrar's Signature

Septem .

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State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Cei	rtificate of i	Death	R	eg. No. )   7	01691						
F	Physici	an	Decedent's Name (First, Middle,     GENE ANTHONY	Last) BARNABIE				2. Date of Dear Month	Day Year	3Time of Death						
	/Medic	al	4a. Facility Name (If not institution,			4h City Town or	r Location of Death	January	4c. County of Deat	6:00 a M						
	Examin	er	9108 Knox Court	give street and humber)		Laurel			Howard							
	Funeral			6. Sex 7. Age ( <i>In yrs</i> . 1	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV • 16	, Year) 9. Birt	hplace (State or Foreign untry) V Jersey						
	Director		138-01-5361 Usual Residence of Decedent	X''' 2 89	115.			NOV. 16	, 1917 Nev	v Jersey						
	yland now at		10a. State 10b. County	10c. Cit	, Town or Lo	ocation				10d. Inside City Limits						
	e Mar la-f sh tiffed	ctor	MD Howar	d La	aurel					1 □ Yes 2√TNo						
	vith th	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?						
	eath v	Funeral	9108 Knox Court  11. Marital Status	12. Was Decedent Ever in U.	S 112	20723	ienanie Origin? (Sn	ocify Voc or No	U.S.A.	rican Indian						
<b>'</b> O	r item	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?			lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White							
<u>8</u>	ours a		<b>¾</b> Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2□XXVo	Specify:		Specify: Wh	nite						
5	ר 72 h "natu edicai	Completed by	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	dent's Usual Occup kind of work done	ation during most of worki d)	ing	16b. Kind of Business/	Industry						
Maryland 21215-0036	withir iene. than	ошо	Elementary/Secondary (0-12) Grade 12	College (1-4or 5+)		pector	<i>1)</i>		Campbell So	oup						
р Б	e filed Il Hyg other	Be C	17. Father's Name (First, Middle, L.	ast)		-	18. Mother's Name	(First, Middle, I	Maiden Surname)	<del>_</del>						
/lar	Menta Menta arked	To E	Florindo Barnab	ie			Elsie Ju	ilianov	0							
/ar	2 sho		19a. Informant's Name/Relationshi	,					r, City or Town, State, Z							
e,	ss 1 and 2 of Health a item 27 is other trau		Dennis Michael  20a. Method of Disposition				rt Laure		land 2072:							
altimore,	ages ent of It: If It y or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spi	X Artemoval from State		osition <i>(Name of</i> matory or other plac Cemetery		1	Cherry Hill	·						
alti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any fijury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Signature of Funeral Service Li				ss of Facility ral		<b>-</b>	, , , , , ,						
<u>~</u>	permii Depar Impor any Ir		142 54	/ M0077	`			-	1, Maryland	20707						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death													
V.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Complication		Colon Ca	ncer			Criset and Death						
	Examiner		,	Due to (or as a consequ	uence of):											
	No.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury	b. Due to (or as a consequent	uence of):											
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c												
60,	be exectan a	E	resulting in death) Last	Due to (or as a consequ	tence of):											
68760,	certificate be executed Iding physician and ise as the burial-transit	Medical		d												
×	0 0 8	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna	ncy	D=-4i			23d. Date of deli	ivery						
. Bo	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ∐Live birth 2 ∏Feta 4 ∏Pregnant at time of d 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year						
<u>Р</u>	hat the d by the	Phy	9 Unknown  Part II. Other significant condition		ulting in the u	ndarlyina eauea giy	on in Port I	220 Did to	bacco use contribute to	the source of death?						
ds,	signe d be d	ş by	Congestive Hear	*	many in the d	ndenying cause give	en in Fait i.		es 2∐No 3XIPr							
cor	w requir been si should b	Completed by	Chronic Obstruc	tive Pulmonary	Diseas	e		24a. Was a		topsy findings available						
Be	The lay te has age 2	omp						autops perfori	sy prior to d	completion of cause of						
Ita	stiffica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Death			2/2/10						
<u> </u>	hysic this ce al dire	P	1 ☐ Yes 2√√No		ER/Outpatier		T I Trainering The		ence 6 Other (Spec	cify)						
Division or Vital Records,	ding F n. After funera	ion:	27. Manner of Death  12 Natural 5 ☐ Pending  2 ☐ Accident investiga	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	yat k? Yes 2∐No	28d. Describe ho	ow injury occurred							
/isi	Atten r deat ector: by the	fica	3 Suicide 6 Could no	t be 28e. Place of injury - At ho	me, farm, str				treet and Number or Ru	ıral Route Number,						
ó	tal or s afte al Dir	Certification:	4 Homicide determin	building, etc. (Specif	() 			City or Town	n, State)							
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		(Check only 2 Medical E	Physician: To the best of my kno xaminer: On the basis of examina	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	and due to the c	ause(s) and manner as late and place, and due	stated. to the cause(s)						
	o the ithin 2 o the omplet	Medical	29b. Signature and title of certifier	and manner state.		29c. License			9d. Date signed (Monti	1.						
	F 3 F ŏ		1 Kinney	us Sand			17135		January 2							
7	10		30. Name and address of person w	ho completed cause of death (Item	23a) (Type,				1							
	,		Lawrence Swink,			th Drive	Columbia	a, Maryl	and							
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	DB442										
			JAN 2	I LUUI MALANA	-					]						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State of Maryland		artment of I <i>rtificate of</i>		7	giene Reg. No		0   685			
			1. Decedent's Name (First, Middle, Las	st)				2. Date of De	ath		3. Time of Death			
	Physici /Medi		Ruth Ann	Brown				Januar	Da:		10:35 A M			
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of D			County of Death				
			104 West Heathe			Bel Ai				Harford				
	Funeral		Social Security Number     6. Security Number	ex 7. Age (In yrs. last		If Under 1 Year Months Days		Hrs. 8. Date of Bird Vin. (Month, Da	h y, Year)	9. Birth	place (State or Foreign intry)			
	Director		147-26-1451 Usual Residence of Decedent	75	Yrs.					1931 New				
	and		10a. State 10b. County	10c. City, 1	Town or Lo	ocation					10d. Inside City Limits			
	Many f sh	ō	Maryland Harfo		- T 7\						1 ☐ Yes 2€ No			
	the 28e	Director	10e. Street and Number	ла в	el A	10f. Zip Code			10a. Cit	izen of What Co	intry?			
	72 hours after death with the Maryland netural', or Itama 23a or 28e-f show disal Examinat must be incitiled at		104 W. Heather Rd			2101	ΙΔ		_	JSA				
	ma 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13.			? (Specify Yes or No uerto Rican, etc.)		14. Race - Amer				
9	after or Ita	교	1 ☐ Never Married 2 💆 Married	Armed Forces?  1 Yes 2 No	1			uerto Rican, etc.)		Black, White	, etc.			
03	ral',	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1⊡Yes 25thNo	Specify:			Specify: Wh	ite			
21215-0036	72 h 'netu	Completed	15. Decedent's Ed (Specify only highest gra	lucation 1 de completed)	16a. Dece	dent's Usual Occur kind of work done DO NOT use retire	pation during most of	working	16b. K	ind of Business/l	ndustry			
2	within ene. than "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)			nd)	J						
	filed withi Hygiene. other than ant, the M		d 7 Cabada Nama / Ciana Adiddla da an	5+	Cher	nist	1				anufacturer			
and	be fi	Be	17. Father's Name (First, Middle, Last)				i _	Name (First, Middle,		•				
Yla	2 should be filed withir and Mental Hygiene. is marked other than aumatic avant, the M	٩	Alfred Joseph Zi				-	el (nmn) G						
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "netural", or Itama 23s or 28e-f show may injury or other traumatic avant, the Medical Examiner must be notified at ance.		19a. Informant's Name/Relationship (7	ype, Print)				r Rural Route Numbe	1000.000	ersers	· · · · ·			
	1 and Health am 27		Hugh Brown/ Spou 20a. Method of Disposition				ner Rd.	, Bel Air,		-				
Baltimore,	Pages nent of H int: If its iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐	3 □Removal from State cemetery, crematory or other place)										
ţi	t. Pa rtmer rtant:		`4 □ Domation 5 □ Other (Speolity	, DC.		's Episco				ngdon, M	aryland			
Bal	permit. Pag Department Important: I eny injury o	-	21. Signature of Funeral Service Licen	SPOR A	Mx	2. Name and Addre COMAS Fi	ess of Facility Ineral I	Home, P. A	١.					
-	402 0 G		and the	/ aicht	150	) W. Broa	adway, I	Bel Air, M	lary.	Land 210	14 Approximate			
			shock, or heart failure. List only one cause on each line.											
	Physician		disease or condition resulting in death)	a metabolic	~	veaku	a cob.	celticy			Onset and Death			
	/Medical Examiner		Toolaring in doubly	Due to (or as a consequen	ice of):									
		<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequen	ce off.									
	nsit 🔨 ed	ulu ulu	Causa (Disease of Injuly	Dao 10 (51 a3 a 0011304a011	100 017.									
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c	ice of):			_						
8760	ate be ex nysician he buria	cal		d										
687	ficate phys s the			0										
XO	death certifica attending pt d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	,					23d. Date of deliv	env			
ğ	death atte	clai	in the past 12 months?	1 Live birth 2 ☐ Fetal de 4 Pregnant at time of death		Ectopic pregnanc Other (specify)	у		1	Month	Day Year			
0	that the de ed by the detached	nysi	9 Unknown	9□ Unknown		(-,,/								
٥.	res that igned b		Part II. Other significant conditions of	ontributing to death but not resultin	ng in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?			
rds	n sign	d by	Lenkemia					1 🗀 Y	es 2	No 3∏Pro				
Ö	w requir been si should	ete	evarian c	arcinoma							bably 4 Unknown			
~	>	=						24a Was	20	24h Wara aut				
Rec	he lav e has	jumo						24a. Was a autop	sy	24b. Were auto prior to co death?	opsy findings available impletion of cause of			
tal Records,	The lar	Completed	25 Was case referred to modical					autop perfor 1 Yes	sy med? No	prior to co	opsy findings available			
	sician: The lav certificate has irector, page 2	Be	25. Was case referred to medical examiner?	Hospital:	10.1-1	ot occording		autop perfor 1 Yes  Death (Check only or	sy med? > No ne)	prior to co death? 1 🗆 Yes	opsy findings available impletion of cause of			
of Vital	Physician: The lav r this certificate has oral director, page 2	To Be	examiner?	1   Inpatient 2   ER		t 3 DOA	ier: 4 ☐ Nursin	autop perfor 1 Yes  Death (Check only or 19 Home 5 Resident)	sy med? No ne) ence	prior to co death? 1 □ Yes	opsy findings available impletion of cause of			
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of Vital	ding Physician: n. After this certifica funeral director, 1	Medical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who of	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At home building, etc. (Specify)  28ician: To the best of my knowlediner: On the basis of examination and manner stated.	b. Time of Injury  o, farm, stri  dge, death and/or inv	28c. Injury  M  1 □ eet, factory, office  1 occurred at the til vestigation, in my office  29c. Licens	y at k? Yes 2 No	autop perforing the perforing the perforing the perforing the perforing the perforing the perforing the perforing the perforing the performance of	symed? No ne) ence (ence ow injur itreet anim, State, date and	prior to code	ppsy findings available impletion of cause of 2 No  fy)  al Route Number,  stated. o the cause(s)  Day, Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year EDNA JANKARY 1356 PM BOGGAN 2.2 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITAL RANDALLSTOWN NORTH WEST If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Min 1 □ M 2 1 F 216-14-4255 9 Z Yrs Director MARY AND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BAltImore RANDALL MARYIAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U-S.A 21133 5412 0 ld Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene.

Is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk HOLLINS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should b ment of Health and Menta tant: If Item 27 is marked Dermott ပ္ OWAN MICHACI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SR. 1 to Thomas W 121 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of I
Important: If It
any Injury or o
once, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State JAN 24, 2007 Baltimere MANY/AND 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FUNERAL Home Jr. Char BAITO MD 5. CONKLING ST. 23a. Part1. Enter the lisea a or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiae arrest /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last myounder Due to (or as a donsequence of): Examiner that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2☒ No 24a. Was an this certificate has autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

State

fit propreh

Fi+2patrick

32. Registrar's Signature

. Mp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wats on

31. Date filed (Month, Day, Year)

JAN 2 4 2007

Doo59736

Northwest Hospital

2007

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mar	yland .		artment of H rtificate of L		ind Me		iene	07	01688
			1. Decedent's Name (First, Middle,	Last)					2	. Date of Dear	th Day	Year	3. Time of Death
	Physicia /Medic		Emma	М.		С	oulbourn			Januar		2007	12:00 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or	Location of	f Death		4c. County		
E			368 Dogwood Roa	ıd			Miller				Anne	Aru	ndel
	Funeral		5. Social Security Number	5. Sex 7. Age ( 1 M 2 D €	(In yrs. last		If Under 1 Year Months Days	If Under 2 Hours	Min.	. Date of Birth (Month, Day)	Year)	9. Birth	place (State or Foreign ntry)
Н	Director		213-09-8683 Usual Residence of Decedent		9	Yrs.			M	arch 2	0,1917	Mar	yland
	end **		10a. State 10b. County	1	10c. City, T	own or Lo	eation			-		1	10d. Inside City Limits
	Many l	ō			D 1								1 ☐ Yes 2 ☐ No
	r the Marylend r 28a-f ahow	Director	Maryland Anne 10e. Street and Number	Arundel	Balt	imor	e 10f. Zip Code			1	0g. Citizen of	What Cou	ntry?
	3a or	<u> </u>	134 Greenland Be	ach Dood			21	226					
	after death with the Marylend or Itema 23a or 28a-1 ahow rutter court be notified at	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13.	Was Decedent of Hi	spanic Orig	gin? (Specif	fy Yes or No-		ce - Ameri	can Indian,
		Ē	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 ☐ Yes 2 ☑ No	1		If Yes, specify Cubar		, Puerto Rio	can, etc.)		ck, White,	etc.
200	hours after tural", or Ita	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☑ No	Specify:			Specil		hite
		Completed	15. Decedent's (Specify only highest	Education grade completed)	1	6a. Dece	dent's Usual Occupa kind of work done of	ation Juring most	of working		16b. Kind of B	usiness/In	ndustry
7	within 72 ene. than "na he Medic	gr	Elementary/Secondary (0-12)	College (1-4or 5+)	)	life.	DO NOT use retired,	)					
N	led w lygier her ti		12	2			Secretar		4- 11 //	F:		. Gra	ce
and	be fi	Be	17. Father's Name (First, Middle, La	ist)				18. Motne	rs Name (/	-irst, Miaaie, i	Maiden Sumar	ne)	
<u>ڇ</u>	J Mer J Mer nark	2	William  19a. Informant's Name/Relationshi	C.		levin		Emma		7	G		Durr
Z Z	h and h and 7 is n						ng Address (Street a						
a)	s 1 and 2 shou f Heelth and M Itam 27 is mar other traumati		Barbara J. Rein 20a. Method of Disposition	ann (Daughte	20b. Place	e of Dispo	Dogwood R	1	iller Dat		Maryla 20c. Location		
Ē	80= 5		1 ☐ Burial 2 ☐ Cremation 3		cem	etery, crei	natory or other place	1	101 10			•	
	iit. Pa artmen ortant: Injury Is		4 □Donation 5 □ Other (Special Service Li		Вауч		Crematory  2. Name and Addres		<u>/24/0</u>	/	Baltin	lore	Maryland
ä	Dep Imp eny		1657	111.		M	cCully-Po 204 Mount	lynia	k Fun	eral H	ome, P.	Α.	
F			23a. Part. Enter the disease, or c	omplications that caused the	he death. [	Do not en	er the mode of dying	ain K g, such as d	oad P	asaden espiratory arr	a, Mary <sub>est</sub>	land	Approximate
	Dhusisian		shock, or heart failure. List o Immediate Cause (Final	4.1			. 1100		۳.0		c		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a			E HEA	(	Y13	silkr	2		njeur
	Examiner			Λ.	RIN		IBRILLA.	710W	•				News
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequen	ce of)n			Λ	1	1		-
*	cuted	Examiner	that initiated events	· a cul	hulor	ales	tu Cori	in Arid	HR	TERY 1	1 1580	33	2 yens
O	sicien and burial-transit	Ex	resulting in death) Last	Due to (or as a	consequen	ice of);							
9/8 8/60	law requires that the death certificate be executed so bean signed by the attending physicien and 2 should be detached for use as the burial-transit	dicat		d									· · · · · · · · · · · · · · · · · · ·
õ	eath certific attending p	Mec	IF FEMALE:		0.7								
ROX	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal de	ath 3[	Ectopic pregnancy					ate of deliver	ery Day Year
o.	at the de by the a rtached (	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4□Pregnant at tir 9□ Unknown	me or deat	n 5L	Other (specify)						,
<u>.</u>	that the ded by	by Physician/Me	Part II. Other significant condition	s contributing to death but	not resultin	ng in the u	nderlying cause give	n in Part I.		23e. Did to	bacco use con	tribute to t	he cause of death?
Hecords,	w requires that been signed b should be deta		8	LEEP APR	18A					1 🗆 Y	es 2 No	3 🗆 Prol	bably 4 Unknown
Ö	w req beer shou	Completed	. (	lunia Od	Pelso.	A. A	Pallan	1 1/1	7	24a. Wasa	246	More aut	ancy findings available
Ĭ	sician: The law certificete hes t irector, page 2 s	d mc		2º Palmo	1.000	, 1	J. Memy Mr	7 200	reng	autops	ned?	death?	opsy findings available impletion of cause of
Vital	ifficet or, pe	e C	25. Was case referred to medical	7 14000	WITCH	1	14/4/1808	OS Plans	of Dooth (	·	-	1 🗌 Yes	2 No
	Attending Physician: r death. ector: After this certific by the funeral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1  Inpatient	2 □ FR	/Outpatier	nt 3 DOA Othe			Check only on 5 ☐ Reside		her (Specil	PAUCHTERS
<u> </u>	9 Physer this seral di		27. Manner of Death	28a. Date of Injury		b. Time o					ow injury occur		M) RESIDENCE
Ö	r Attending P er death. rector: After I by the funera	atio	1 Anatural 5 ☐ Pending 2 ☐ Accident investiga	ation	, 647	inquiy		Yes 2□N	No				
Division of	l or Attendetter death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		y - At home (Specify)	, farm, st	eet, factory, office		28	Location (Si City or Town	reet and Numi	ber or Run	al Route Number,
Ξ	Ital or A												
1	To the Hospital or within 24 hours effe To the Funaral Director completely filled in I	cai	(Check only 2 Medical E	Physicien: To the best of xeminer: On the basis of e	xamination	dge, deat and/or in	h occurred at the tim vestigation, in my op	e, date and pinion, deat	d place, and	d due to the ca	ause(s) and m ate and place.	anner as s	stated. o the cause(s)
)	thin 2 thin 2 the i	Medical	one) 29b. Signature and title of certifier	and manner state	ed.		29c. License				9d. Date signe		
	Ž Š Ž S		• AA1	2			_		75	1	_		/ :
	li		30. Name and address of person (	And a	ath (Itom Of	1a) /T	Dei-th		. )	-	01	1	/
	11		Dimichus	X E. Gu Co	chy 23	d'C.	FI Ft. S.	، المه	brow	10 5	r. I Pa	Jude	2007
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar		Core	1/3						2/11/5

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Dates:

1 🗌 M

Prince George's

7. Age (In yrs. last birthday)

10c. City, Town or Location

10f. Zip Code

1 ☐ Yes XX No

20708

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Laurel

64

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, interportant, or items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the <u>Medical Examiner must be notified at ones.</u> orice. Baltimore, Maryland 21215-0036

**Funeral** 

Director

5. Social Security Number

Maryland

11. Marital Status

10e. Street and Number

10a. State

Director

Funeral

215-40-0167

Usual Residence of Decedent

8763 Oxwell Lane

Never Married 2 Married

10b. County

**Physician** /Medical Examiner

the burial-trar nse cate has been signed by the page 2 should be detached funeral within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760, 🐟

The law requires that the death certificate be executed To the Hospital or Attending Physiclan:

by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1LIYes XIX	No Specify:			Specify:	White		
sted	15. Decedent's E (Specify only highest gra	ducation		Decedent's Usual Od (Give kind of work do		of working	16b.	Kind of Busines	ss/Industry		
Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	1	iife. DO NOT use re ealtor	tired)	n working	1	Real Est	tate		
To Be C	17. Father's Name ( <i>First, Middle, Last</i> Randolph Bowen	)	-1			s Name <i>(F</i>	irst, Middle, Maid	en Surname)			
-	19a. Informant's Name/Relationship (	Type. Print)	19b.	Mailing Address (Str	reet and Number	or Rural F	Route Number, City	y or Town, State	, Zip Code)		
	Evelyn Lowe / Po	ersonal Rep.	87	63 Oxwell	Lane,	Laur	el, Mary	land 20	0708		
	20a. Method of Disposition  1 ☐ Burial 2 ☑Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.	Removal from State	cemeter	Disposition (Name o y, crematory or other rundel Cr	place)	Date 1/23,	200.	Location - City denton,	or Town, State Maryland		
	21. Signature of Funeral Service Lice			1			ome, P.A Laurel,		nd 20707		
	23a. Part1. Enter the disease or comshock, or heart failure. Let only Immediate Cause (Final disease or condition	plications that caused the deat one cause on each line.							Approximate Interval Between Onset and Death		
	resulting in death)	Due to (or as a conseq		f):							
	Sequentially list conditions,	b		0							
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):  Due to (or as a consequence of):										
xan	that initiated events resulting in death) Last	c Due to (or as a conseq	luence o	f);					-		
		_d									
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2XXNo 9 □ Unknown	23c. If yes, outcome pf pregnation in the control of the control	al death	3 □Ectopic pregn 5 □ Other (specif		_		23d. Date of o	delivery Day Year		
þ	Part II. Other significant conditions of COPD	contributing to death but not res	ulting in	the underlying cause	given in Part I.				to the cause of death?		
eted						- !	I LI tes	Z   NO 3	Probably <b>AX</b> Unkno		
Completed			_			_	24a. Was an autopsy performed?	prior t death			
BeC	25. Was case referred to medical				26 Place o	f Death (C	1⊡ Yes 🏋 Check only one)	No 1 Y	es ZXXNo		
To B	examiner? 1 ☐ Yes <b>¾(X</b> No	Hospital: 1 ☐ Inpatient 2 ☐	I ER/Out	patient 3□DOA			5 ☐ Residence	6 DOthor (Co	nacify)		
tion: T	27. Manner of Death  1XXNatural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. T	ime of 28c.	njury at Work? 1 ☐ Yes 2 ☐ No	280	l. Describe how in	jury occurred	<i>Эвспу)</i>		
Certification:	3 Suicide 6 Could not b determined	e 28e. Place of injury - At he building, etc. (Special	ome, fan fy)	m, street, factory, off	ice	28f.	Location (Street City or Town, Sta	and Number or ate)	Rural Route Number,		
Medical C	29a. Certifier 1	nysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, ation and	death occurred at the	ne time, date and my opinion, death	place, and occurred	d due to the cause at the time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)		
Me	29b. Signature and title of certifier	11		29c. Lic	ense number		29d. E	ate signed (Mo	nth, Day, Year)		
	1 Caust	Heio		D0	053235		Jai	nuary 2	2, 2007		
	30. Name and address of person who Darryl Hill, M.D.				Laurel,	Mary	land 20	707			
to	31. Date filed (Month, Day, Year)	32 Registrar's Signa		Avenue	Taurer,	rat y		7 0 7			
ite ar	JAN 2 4 20			Acord 2							

2007

Prince George's

14. Race - American Indian,

Black, White, etc.

4c. County of Death

10g. Citizen of What Country?

U.S.A.

4:20 a M

9. Birthplace (State or Foreign

10d. Inside City Limits 1 ☐ Yes 2 No

Maryland

22,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav 8 SS AM **Physician** 2007 20 Janua ry Naomi Elizabeth Cloman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Nursing Honder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) TIZENS Home tora Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral Months 1□M 2√2F 98 Yrs. Director 9, 1908 218-80-7605 Usual Residence of Decedent Maryland with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State 28a-f show other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or itams 23a 707 Old Philadelphia Rd. 21085 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "natural", or itan any injury or other treumatic event 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Lewis Dubree Bertha Melinda Deaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jack E. Cloman/Son 2707 Franklinville Rd., Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation \_57☐ Other (Specify) Trinity Lutheran 1-24-07 Joppa, Maryland 21. Signature Fineral Service Licensee ·22. Name and Address of Facility
McComas Funeral Home, P. A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Ipman. Naomi IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ongestive Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary this certificate has autopsy performe Type II Dic 25. Was case referred to medical examiner? Diabetés 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To or Attending Plater death.

I Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 0063981 2007 wo Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Y. Lee Havre de Graco, 669 Revolution MD egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 2 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Day Year Mary DeShazo January 22:10 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore er1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) N/A Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Hours Director 213-30-8300 73 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy fulury or other traumatic event, the Medical Examiner must be notified at once. 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits by Funeral Director X □Yes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7916 Dunhill Village Cir. Apt 203 21244 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black § ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
9th grade College (1-4or 5+) Caregiver Private ná 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Burrell Georgia Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Harris-Daughter Upmanor Road, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1/25/07 Cedar Hill Baltimore, Md 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 days Heart AHACK /Medical Due to (or as a consequence of): **Examiner** 20 years Covency arkey disease Sequentially list conditions, if any leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death Division or Vital Records, P.O. 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of has death? certificate 2 No 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 The patient 1 Yes 2 No Other: 2 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) I Director: After to in by the funeral 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946 Mexander January 20, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nD union memorial Hospital, MD Janelle Alexander 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 2 4 200

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	W0.145-		1 - For State Registrar	State of Maryla		artmen rtificat			and Me		gienez Reg. No.	007	01693
	Physici	an	1. Decedent's Name (First, Middle, La							<ol><li>Date of De. Month</li></ol>	ath Day	Year	3. Time of Death
	/Medic		MARY V	DORSEL	1					MNUARY		2007	06:00 AM
	Examin	er	4a. Fecility Name (If not institution, giv	e street and number)				Location of			4c. Co	unty of Dea	
			Levindale Hebrew 6.5	Ger. Center	& Hosp.	If Lindor	Balti 1 Year	more If Under		n Data at Bid	Nt.	N/A	
10,44	Funeral		403-26-0564	N 2  F 82	. <i>iast oirthday)</i> Yrs.	Months	Days	Hours	Min	8. Date of Birl (Month, Da April	v. Year)	Co	thplace (State or Foreign
-0.6	Director		Usual Residence of Decedent	02						APLII	9,192	+ Kei	itúćky
	yland ***		10a. State 10b. County	10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
	Mar.	ţō	Maryland Anne A	Arundel	G1er	Bur	nie						1 Yes 2 No
	or 28	<u>e</u>	10e. Street and Number			10f. Zip	Code				10g. Citizer	of What Co	ountry?
	23a c	a	7980 Americana Ci	ircle Apt 104			21	.060			Ţ	J.S.A.	
	de de de de de de de de de de de de de d	ner	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spec	ofy Yes or No lican, etc.)	- 14.	Race - Ame Black, Whit	erican Indian,
98	or th	J.	1 Never Married 2 Married	1 ☐ Yes 2 🖢 No		1 ☐ Yes		Specify:	,	, , , ,			Mhite
8	72 hours after death with the Maryland natural; or items 23a or 28a-f show deal Examiner must be notilied at	D D	3 ☐ Widowed 4 ☑ Divorced	Year or Dales:									
21215-0036	n 72	Completed by Funeral Director	15. Decedent's Education (Specify only highest gradual)		16a. Dece	dent's Usu kind of wo DO NOT u	rk done d	luring mos	t of workin	g	16b. Kind	of Business	Industry
12	within ene.		Elementary/Secondary (0-12)	College (1-4or 5+)		ialys	111	,			1	N.S.A.	
d 2	Hygid Hygid Sther		17. Father's Name (First, Middle, Last,					18. Mothe	er's Name	(First, Middle,			<u>'</u>
an	id be ental ked c	To Be	Herbert Wil	lder				A	rizon	a	Woote	en	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Madical Examinar must be notified at	-	19a. Informani's Name/Relationship (	Type, Print)	19b. Maili	ng Address	(Street a	nd Numbe	er or Rural	Route Numbe	er, City or To	own, State, a	Zip Code)
	1 and 2 Health a am 27 is		Michael F. Dorsey	y (Son)	2954	E. A.	1mond	lbury	Driv	e, Pas	adena.	, Mary	land 21122
J.	of Health of Health litem 27		20a. Method of Disposition		Place of Dispo	osition (Nai	ne of other place	e)	Da	ate	20c. Local	ion - City or	Town, Stale
Ĕ	Pages nent of h int: If its		1 <b>I</b> Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 5 □ Other (Specification Specification Speci	y) Me	adworid			- 1	01-24	-07	E1kri	dge, M	laryland
Baltimore,	permit. Page Depertment of Important: If any injury or once.		21. Signature of Funeral Service Licer	1599	Mic	2. Name ar	nd Addres	s of Facilit	k Fun	eral H	ome P	. A .	ıd 21122
_	70 E # 9		The S	percun								arylan	id 21122
	Physician /Medical Examiner	4	23a Mart. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each line.	ARTERU		SEAS		cardiac or	respiratory a	rresi,		Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed to has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.)									
9	ng ph	Med	IF FEMALE:										
P.O. Box	that the death certific ed by the attending p detached for use as i	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	⊒Ectopic pi ⊒ Other (sp					23d	. Date of dei Month	livery Day Year
Records, P	puires that n signed b	ρχ	Part II. Other significant conditions of	ontribuling to death bul not re	sulling in the u	nderlying o	ause give	n in Part I		23e. Did to			the cause of death?
00	aw requir s been si 2 should l	Completed								24a. Was		4b. Were au	Jopsy findings available
Re	The lay	E O								autop perfo	ormed?	death?	completion of cause of
of Vital		0	25. Was case referred to medical					26. Place	of Death	(Check only o			
f V	nysic nis ce direc	To B	examiner?	Hospital: 1 Inpatient 2	ER/Oulpatier	n 3□ D0	Othe Othe	or: 4 □ Nu	irsing Hom	e 5 Resid	dence 6	Other (Spe	cify)
0	ding Physicien: The I h. After this certificate ha funeral director, page		27. Manner of Dealh 1 ☑Natural 5 ☐ Pending	28a. Dale of Injury (Month, Day Year)	28b. Time o Injury	f 2	28c. Injury Work	at ?	2	8d. Describe I	how injury o	ccurred	
Sio	eath. or: A the fu	catio	2 Accident investigation			М		/es 2 □	No				
Division	tal or Attendi s after death al Director: A ed in by the fi	Certification:	3 Suicide 6 Could not b 4 Homicide determined		nome, farm, sti ify)	reet, factor	y, office		2	8f. Location (: City or Tox		lumber or Ri	ural Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	29a. Certifier Contifuing Pt (Check only one)	nysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred vestigation	at the time, in my op	e, date an inion, dea	d place, a	nd due lo the d at the time,	cause(s) an date and pla	d manner as	s stated. e to the cause(s)
	To the vithin To the Comp	Ž	29b. Signature and title of certifier	٥		290	c. License	number			29d. Date s	igned (Mont	h, Day, Year)
	/		( Dinna m.	arenly m	.0		Dos	5473	9	1	JANUA	ry 2	1st 2007
	5		30. Name and address of person who										
				redere Aven		Balt	inv	e 1	nan	plano	1 213	215	
200	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Sign	di do	me							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMN IIIM/I 4b.perHis.//Illa-Iuf.perHi.063.1/24/07.WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Day Th Zon 1. Decedent's Name (First, Middle, Last) Duval1 2. Date of Death Patricia Maria Month **Physician** ATRICI bruan 10.10A.M /Medical 4b. City, Town, or Location of Death Randallstown 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner If Under 1 Year Northwest Hospital 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 213 - 86 - 8466 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 200 F Maryland Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "netural", or iteme 23a or 28a-t ehow the Medical Examinar must be notified at Baltimore **Baltimore** 1 Yes 2 No by Funeral Director MD dallslu 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21207 Townbrook Dr. Apt. D 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give / Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2☐ Married Baltimore, Maryland 21215-0036 Specify Black 1 ☐ Yes 2 💢 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Jamestic )Omestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental I Pages 1 and 2 should be Frank Duvall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oylyia. 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar important: it item 27 ie any injury or other treu 20b. Place of Disposition (Name of cemetery, crematory or other place)

NH-Zion Bandoll Hum Date 20c. Location -Sister Irreresa Fucher 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State 22. Name and Address of Facility augmon C. Graine Furreral Struck 4 ☐ Donation 5 ☐ Other (Specify) mi 21. Signature of Funeral Service Licensee 1 aughor C 8728 Liberty Road handallstown, MO 21, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Human immunodolicery Idvance **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examine the attending physician and thed for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 NM 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☐ No 1 Umpatient 2 ER/Outpatient 3 DOA After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No i Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral completely filled 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 19 2007 Northwest Huspital 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Way Amar J. Kangaran J. Kang 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

	1	For State Registrar	State of Maryland	/ Depa	irtment o	f Health a	and Mei		ene2 () () 7	01695
Physiciai /Medica Examine	1	1. Decedent's Name (First, Middle, Last)  A. Facility Name (If not institution, give street	Pietsch		4b. City, Tow	n, or Location o	of Death	Date of Death Month	20 200 4c. County of Dea	
Funeral Director		5. Social Security Number 6. Sex 1 Number 100. Sex 1 Number 100. County	7. Age (In yrs. las	Yrs.	If Under 1 Ye Months Da		_	Date of Birth (Month, Day, arch Il	N/A Year) 1924Mar	
nd 21215-U oe filed within 72 ho tal Hygiene d other then "natura event, the Medical i	lo be Completed by runeral Director	MD N/A  10e. Street and Number  155 Grundy Street A	Apt. 135  Was Decedent Ever in U.S. Armed Forces? 1	Balt  13. V  16a. Deced (Give iffe. L  Seams  19b. Mailin  10913  ce of Disponetary, crem red He	Imore  10f. Zip Coc 21  Nas Decedent Yes, specify ( Yes, specify ( Yes 2   In the specify ( Yes	224  of Hispanic Oricuban, Mexican  No Specify: coupation one during most  18. Mothe  Min reet and Number  of place)  Jesus1  ddress of Facility	er's Name (Fanie More Lau: Date 1/23/0 ty Char	y Yes or No- an, etc.)  First, Middle, M eibahm  Toute Number, rel, MI  7 les S.	Og. Citizen of What CUSA  14. Race - Am Black, Wh Specify: Wh  16b. Kind of Busines:  Clothing faiden Surmame)  City or Town, State, D 20723  Coc. Location - City of Baltimore Zeiler and Core, MD 21	erican Indian, ite, etc. ite s/Industry  Zip Code) r Town, State
Ite be sysicie	Ical Examin	23a. Parn. Er er the sease or complica show of heart failure. ist only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	oue to (or as a conseque	Do not entread of the contract	er the mode of		cardiac or re	espiratory arre		Approximate Interval Between Onset and Death  WWW.
P.O. BOX 61 at the death certific by the ettending p etached for use as	nysician/	in the past 12 months?  1 Yes 2 No 9 Unknown	If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	eath 3☐ th 5☐	Ectopic pregna Other (specify	)			23d. Date of do Month	Day Year
Hecords, The law requires the hes been signe age 2 should be d	Completed by	Part II. Other significant conditions control	buting to death but not result	ing in the ur	nderlying cause			1 🗆 Ye  24a. Was ar autopsy perform 1 🗆 Yes 2	24b. Were a prior to death?	to the cause of death?  Probably 4 Unknown autopsy findings available completion of cause of s 2 No
OIVISION OF or Attending Phy lifer death. Inctor: After this in by the funeral d	0	25. Was case referred to medical examiner?  1  Yes		R/Outpatien 8b. Time of Injury ne, farm, stra	28c.	Other: 4 Nu Nu Niury at Work? 1 Yes 2	ursing Home 28d	d. Descri <b>be</b> ho	nce 6 Other (Sp w injury occurred	
To the Hospita within 24 hours To the Funerel completely filled	Medical	29b. Signature and title of certifier	ian: To the best of my knowler: On the basis of examination and manner stated.	n and/or in	29c. Lid	ense number	ath occurred	at the time, da	ause(s) and manner at the and place, and du dd. Date signed (Mor	e to the cause(s)
State Registra	e r	31. Date filed (Month, Day, Year) JAN 2 4 201	N Strain  32. Registrar's Signatu		asoli 9					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 12:05 P.M WILLIAM JOHN DELANEY 20 200 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Bathmere Washington Wedical 5. Social Security Number 6. Sex 7. Age (In Anne 8. Date of Birth (Month, Day, Yes If Under 1 Year if Under 2 Hours 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Min. Year 1 X M 2 □ F Director 215-14-8221 86 SEPT. 1920 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits Examiner must be notified at Director MARYLAND ANNE ARUNDEL SEVERN 1 ☐ Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 115 OTIS DRIVE 21144 UNITED STATES Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 N Yes 2 No If Yes, Give 1942 — Year or Dates: 1945 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced þ WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER RATTROAD 6 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be ealth and Mental WILLIAM DELANEY WINIFRED LOFTUS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If item 27 Is any Injury or other trau once. PATRICK DELANEY / NEPHEW 115 OTIS DRIVE SEVERN, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place)
NEW CATHEDRAL CEM. 20a. Method of Disposition
1 ☑ Buria! 2 ☐ Cremation 3 ☐ Removal from State JAN. 23. 20c. Location - City or Town, State 4 Donation 5 Dother (Specify) 2007 BALTIMORE, MARYLAND 21. Signatur f Funeral Service Moenses 22. Name and Address of Facility KIRKLEY CRAIN HWYCK FUNERAL HOME PA. MD 21061 23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. immediate Cause (Final disease or condition resulting in death) **Physician** Neumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 (Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation Injury s after dea. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral C completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jany 20, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Francis, M.D WAShing ton

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

December 1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 20, 2007 1:20 P.M RENNA M. DASCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OAK CREST CARE CENTER PARKVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8/16/1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2X F MARYLAND 220-07-4600 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Funeral Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or aminer must be r 8828 WALTHER BLVD. #217 21234 death USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. event, the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify. Completed by WHITE 3 ☐ Widowed 4 ☐ Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN OWN SHOP 8TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS PILKERTON မ RENNA BILMEYER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6599 GRAMBY NOTCH SW RUTH POWERS/NIECE SUNSET BEACH, NC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARDENS OF FAITH CEM. Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 1/23/2007 PARKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Fun ral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** disease or condition resulting in death) cancer pancreatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) burialphysician s the buria Physician/Medical anding p 38 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a Id be detached f 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 donknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ₩0 has autopsy performed certificate 2 40 1□ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: A d in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital or within 24 hours aft

To the Funeral DI

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

JAN 2 4 2007

Aman

31. Date filed (Month, Day, Year)

mic 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



8800

Maryland 2121

Baltimore,

P.O.

Records,

Division or Vital

)5864L

		sic ledi amii
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours site toeart.  To the Funeral Director: After this certificate has been signed by the attending physician and

		Please Type or Print in Black Indelible Ink. Ensure  State of Maryland / Department of Health and  1- State Registrar  Certificate of Death	-	_	e. 7 01599
Physicia		1. Decedent's Name (First, Middle, Last)  CHARLES A. GAMBRILL, JR.	2. Date of D Month	eath Day Y	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deal Rose do let Social Security Number  5. Social Security Number  6. Sex  7. Age (Ih yrs. last birthday)  WWM 2 F 83  Yrs. Months Days Hours Mit	's. 8. Date of B	4c. County of  BO/ irth pay, Year)  9	Death  Limore Birthplace (State or Foreign Country)
Ital Hygiene.  Ital Hygiene.  Id other then "natural, or Itema 23a or 28a-f show be other then "natural, or Itema 23a or 28a-f show be other than Medical Examinar must be publised at a company.	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Baltimore White Marsh - Baltimore  10e. Street and Number 10f. Zip Code		24,1923	MARYLAND  10d. Inside City Limits  1 □ Yes 2 □ 100  at Country?
Department of Health and Mental Hygiene. Important: or Items 23s or 28s-f show Important: If Item 27 is marked other than "natural; or Items 23s or 28s-f show ery injury or other treumatic event, the Medical Examiner must be nutified at once.	by Funerai	10416 Vincent Farm Lane  21162  11. Marital Status  1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 □ No WW 11 Yes, specify Cuban, Mexican, Pue Year or Dates: 1 □ Yes 2 No Specify:	(Specify Yes or Nerto Rican, etc.)		American Indian, White, etc. White
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nd Mental Hi marked oth umatic even	To Be		e Vincen	t	ate. Zip Code)
nent of Health and int: If Item 27 is new or other traum	Total Calendaria	Charles A. Vincent III (Son) 10403 Vincent Farm I	_ane Wh	ite Marsh,	Md. 21162 ty or Town, State
Departmentimportant:  eny injury once.	77.	1 Deurial 2 Committee 3 Parimoval From State 4 Donation 5 Other (Specify)  21. Signature 1 Funeral Service Licensee  22. Name and Address of Facility Lassahn Funeral	Home 7	Baltimor 401 Belain altimore,	
D IC	cal Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  List only one cause on each line.  a. List of Company of Com	nath y		Onset and Death
ed by the attending physic detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	707-2	23d. Date Month	
n signed by uld be deta	ρ	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.			ute to the cause of death?
certificate has been signed by the attending physector, page 2 should be detached for use as the	e Completed		1 ☐ Yes	topsy prie rformed? dea : 2X No 1 □	ore autopsy findings available to completion of cause of ath?  Yes 2 □ No
fter this	ToB	examiner? 1 Yes 25 No Hospital: 17 Inpatient 2 EP/Outpatient 3 DOA Cther: 4 Nursing		sidence 6 Other e how injury occurred	
rs effer des al Directo ed in by th	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	(Street and Number own, State)	or Rural Route Number,	
within 24 hours efter death. To the Funeral Director: After	Medical		ccurred at the tim		d due to the cause(s)
2+1 Sta	te	30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)  30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature		altimore,	MD 21.37
Registr	rar	JAN 2 4 2007 Describer 15. Specific			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gambrill, Sr. 0850PM rnest 2007 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Hospita Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Unde Hours **Funeral** Days 1**X** M 2□F Months Director Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Iniportant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □ Yes 2 No Funeral Director baltimore 'Otonsville 10e. Street and Number 10g. Citizen of What Country? U.S.A 14. Race - American Indian, Hal . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VCar3 Electrical Engineer Ripartinent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Ganbrill

19a. Informant's Name/Relationship (Type. Print) ٥ Stelle Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Park Heights Avenue. Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any Injury or o once, 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 01.29.2007 Bultimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Voughn C. Greene uneral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 728 liberty Red. Rundallstown MD 21133 Approximate Interval Between Onset and Death Anoxic **Physician** 1 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine iding physician and ise as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🛣 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l page 2 s autopsy perform certificate Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 0 this After thi 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 1 Natural 2 Accident Division (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: of completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10

State Registrar 32 Registrar's Signature

Medical

O 2 degirmence

30. Name and dodess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Mattie Μ. Hawkins 18th ( 10 AM MAL 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A St. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F 82 Director 07 213-28-8431 13 24 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4803 Tamarind Road Apt 325 21209 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎗 ☐ No Specify. Specify: Black ģ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Peay Sr. Maggie Peay 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Kimberly Langton-Daughter 6611 Eberley Drive, Apt 201, Balto, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 1/26/07 Owings Mills, Md 21. Signature of Funeral Service Licensee March F/H West 23a. Party. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. List only one cause on each line. Venala 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Imme v te Cause (Final disea or condition resulting in death) **Physician** Metastatic UDa /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by diseas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Hypertension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No certificate has autopsy performed' Vital Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 2 Accident 5 Pending investigation Division (Month, Day Year) To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the Masis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marner stated. 29a. Certifier (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNE REE DUIJ STAGNES
31. Date filed (Month, Day, Year) 32. Registra 900 CATON AVE HOSPITAL

Registrar DHMH 17 Rev 1/2001

State

SNINS,

32. Registrar's Signature

,	4		Please	ype or Print ir					•		egible.	
	•		For	State of Maryla					ental Hy	giene		
			1 - State Registrar		C	ertificate of	Death			Reg. No. 🤈	007	01703
L			1. Decedent's Name (First, Middle, I	.ast)					2. Date of De			3. Time of Death
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	/Medic		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of		Cap to Care	4c. Co	unty of Death	D.I
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ic.	Director		243-20-6402 Usual Residence of Decedent	83					04 0	3 23	9	NC
	and *		10a. State 10b. County	10c.	City, Town or	Location	-					10d. Inside City Limits
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	be filed within 72 hours after death with the Maryland that lygiene.  Id Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code				rug. Citizer	of What Cou	ntry?
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	ems er m	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 1	<ol><li>Was Decedent of I If Yes, specify Cub</li></ol>	Hispanic Ori pan, Mexicai	igin? (Spec n, Puerto F	cify Yes or No tican, etc.)	)- 14.	Race - Americ Black, White,	
٥	or it		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 🎾 No						
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0	e filed within 7 al Hygiene. I other than "r vent, the Med	Be	17. Father's Name (First, Middle, La	st)			18. Mothe	er's Name	(First, Middle	, Maiden Su	rname)	
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<u> </u>	should I ind Men marker	-	19a, Informant's Name/Relationship		19b. Ma	ailing Address (Street	t and Numb	er or Rural	Route Numb	er. City or To	own. State. Zii	Code) 01100
<u>8</u>	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic		Leon Jones-Sor			6 Sunset				•		21133
ข้	s 1 and 2 of Health Item 27 I		20a. Method of Disposition						ate		ion - City or To	
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аппо	Pa men ant: lury		4 Donation 5 ☐ Other (Spe		Ar	butus		1/25	/07	Arbu	itus,	Md
<u></u>	permit. Pages Department of Important: If II any Injury or once.		21. Signature of Funeral Service Lic	rensee	M	22. Name and Address Arch F/H	ess of Facili	ity				
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0	g Ph er th eral	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Yea	r) 28b. Time				8d. Describe			
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<u>s</u>	Atter dea octor	fice	3 Suicide 6 □ Could not	28e. Place of injury - A		street, factory, office	-	2	Bf. Location (	Street and N	lumber or Rur	al Route Number,
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	plta ours erai filled	Ö	29a, Certifier 1 V Certifying	Physician: To the best of my	knowledge de	eath occurred at the t	time date a	nd place a	nd due to the	021100(0) 20	d manner ee	stated
	Hos 24 hc Fun Fun	edical	(Check only one) Medical Ex	aminer: On the basis of exar	nination and/o	r investigation, in my	opinion, dea	ath occurre	d at the time,	date and pl	ace, and due t	o the cause(s)
	the the mple	Med		and manner stated.		29c. Licens	ee number			20d Data a	inned (Afanth	Day Vanal
	P ₹ 2 8	-	29b. Signature and title of certifier			250. Licens	se number	0		290. Date s	igned (Month,	Day, rear)
	1	1 5	Alile 1-1	Suff			45/	14		Jann	cV6 1	P, 2407
-1			30. Name and address of person wi	no competed cause of death (	Item 23a) (Typ	pe, Print)			,		1	/
			Alilo Hsi	eb LONE	£1.00 1	t His	Sp Ta	3/	RAHE	Allri	toun	merylo
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3: Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **HARRIS** 6:23 P M SELMA 01 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A GOOD SAMARITAN MOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 07/17/1913 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1□M 2√F 213-50-0808 93 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE 1 X Yes 2 □ No N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7111 PARK HEIGHTS AVENUE #602 USA 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No WHITE 3 Nidowed 4 □ Divorced Specify. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NATHAN BERKOW JENNIE SCHWABER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7111 PARK HEIGHTS AVE. #602 - BALTIMORE, MD 21215 JEFFREY HARRIS / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 5 ☐ Other (Specify) 01/24/2007 LUBAWITZ NUSACH ARI ROSEDALE, MD 4 □ Doylation 21. Signature of Funeral Service Lie 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only 30 cause on each line. Immediate Cause (Final disease or condition resulting in death) CRITICAL HORTIC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 month Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHROWIC OBSTRUCTIVE 2 No 3 Probably 4 Unknown 1 TUYES 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performe 2 Lino 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 hpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

**Physician** /Medical Examiner death certificate be executed

Department of Heal important: if item 2 any injury or other

Physician

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

ges 1 and 2 should be filed within 72 hours after death 1 trof Health and Mental Hygiene.

If Item 27 is marked other than "natural", or items 23s or other traumatic event, the Medicial Examiner must

Maryland 21215-0036

Baltimore,

Pages '

Director

Be Completed by Funeral

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burial-trar the use as ģ page 2 should this

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Division or Vital Records,

or Attending Physician:

After

within 24 hours a

completely

Medical

funeral director s after death.

I Director: Af

In by the fur filled in by

Physician/Medical Examiner Completed by Be 卢 Certification:

25.	Was case referred to medic examiner?	al
	1 ☐ Yes 2 ☐ No	
07	14	_

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE

29a. Certifier (Check only 1 Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

BLVD

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VAIDEEP 31. Date filed (Month, Dav. Year) State

4

MINGORANI ,5601 LOCK RAVEN 2. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1417	,	For State Registrar	State of Marylar		artmen rtificat			and M		giene Reg. No.	0.0	7	01705	
H	Dhysiai		1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	ath Day		Year	3. Time of Death	
4	Physicia /Medic	_	Antoinette	М.			dest			Januar	y 21	, 200		5:24 A M	_
	Examin	er	4a. Facility Name (If not institution, give s					Location o	of Death		4c.	County of		umdo 1	
			Anne Arundel Medi 5. Social Security Number 6. Sex	7. Age (In yrs.	last highday	If Under	-	olis	24 Hrs.	8. Date of Birt	h			undel place (State or Foreign	_
	Funeral Director		219-30-6511	M 20 72	Yrs.	Months	Days	Hours	Min.	Jan. 10	v Year		Cou	yland	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation							1	10d. Inside City Limits	-
	Manyl f sho	ō	Maryland Anno An	00	lenton									1 ☐ Yes 2 → No	
	28a	Funeral Directo	10e. Street and Number	under		10f. Zip	Code				10g. Citi	zen of Wh	nat Cou	ntry?	-
	h with	JE D	2606 Hoods Mill Cou	rt			2111	13				U.S.A	Α.		
	deat ms 2	ner	11. Marital Status	Was Decedent Ever in U     Armed Forces?	.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	- [		- Ameri , White,	can Indian,	
92	be filed within 72 hours after death with the Maryland at bygiene. A constant of other then "natural" or items 23a or 28a-f show event, tra Modical Exeminar must be notiliad at		1 Never Married 2 Married	1 ☐ Yes 2 ☑ 10 If Yes, Give	1	1 ☐ Yes		Specify:	,	,		Specify:			
ğ	hours urai',	q p	3 ☑ Widowed 4 □ Divorced	Year or Dates:	16a Doss	domin Unio	d Occurs	ntion		İ	16h Ki	nd of Bus	Whi		
5	n 72	lete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usua kind of wo DO NOT us	n Occupa rk done d se retired	tion luring mosi )	t of workii	ng	100, KI	nd of bus	111622/11	dustry	
212	iene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+) N/A		Homema					Ow	n Hor	ne		
ğ	B = 0 \$	Bec	17. Father's Name (First, Middle, Last)		'			18. Mothe	r's Name	(First, Middle,	Maiden	Sumame			
Maryland 21215-0036	permit. Pages 1 and 2 should be l Department of Health and Mental Important: If item 27 is marked o eny injury or other traumatic eve <u>once</u> .	To	Edward	Walter	Mink	сеу		He1	en					Garvis	
Jan	2 sho		19a. Informant's Name/Relationship (Type			•				Route Numbe				·	
e o	and Health Im 27 Ther to		Gary M. Hardesty ( 20a. Method of Disposition		_ //	-				ate				d 21042 own, State	_
20	if ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	enioval nom State	Place of Dispo cemetery, crea								-		
altimore,	it. Pa intmer intent injury		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License		lar Hil				1/24/					k Maryland	
Ba	perm Depa Impo eny i		21. Signature of Funding Service Electrics	//` .	Ŋ	IcCuI	Ly-Po	olyni	ák Fi	neral l Pasade	Home	P.A	A.	21122	
3			23a. P. 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dear								ildi y.	Land	Approximate Interval Between	-
医骨	Physician /Medical Examiner	ılner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) co	erm		er	en.	si m	$\sim$				Onset and Death	_
68760,	The law requires that the death certificate be executed. The hes been signed by the attending physicien end age 2 should be detached for use as the burial-transit.	edical Examiner	that initiated events cresulting in death) Last	Due to (or as a consec	juence of):										_
.О. Вох	at the death certific by the attending pl tached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	Ideath 3	⊒Ectopic pr ⊒ Other (sp						23d. Date Mont		ery Day Year	
а.	res that igned b be deta	by Pł	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	underlying c	ause give	en in Part I.		23e. Did to	obacco u	ise contrib	oute to I	he cause of death?	
ğ	w require been sig should b									101	res 21	<b>⊒</b> √0 3	B 🗌 Pro	bably 4 Unknown	
al Records,		Completed								24a. Was autop perfo 1 🗆 Yes	rmed?	pri de	ere auto for to co eath? Yes	opsy findings available impletion of cause of	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			Othe			Check only o					
ō	무 두 등	٠ <u>.</u>	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	28b. Time o		/A	4 🗀 Nu		ne 5 Resid				(y)	_
on	ding I th. After funer	tlon	1. ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	8c. Injury Work	k? Yes 2 □				,	•		
Division of	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, factory	, office			28f. Location (S City or Tov			r or Rur	al Route Number,	
	he Hospital in 24 hours a he Funeral i pletely filled	edical		inian To the best of my kinder: On the basis of examination and manner stated.											
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	6		290		number	_			7		Day, Year)	
}			Stoll	L, MD			DS 5	351	0		0	1/2	16	7	
	10		30. N me address of person who co	mple ed cause of death (Ite	т 23а) Туре,	Print)									
. 6%	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Brown									_
3	Registr		IAN Z 4	LUUY MARKET	10	1	-								

			Please T	ype or Print						egible.	
			For 1 _ State	State of Mar	•	epartment of I Certificate of		, ,	0	007	01700
	1.0	a	State     Registrar  1. Decedent's Name (First, Middle, Last)			Jertincate or	Dealli	2. Date of Dea	eg. No./ th	UU/	3. Time of Death
	Physicia	_		STEVENSON	HEGEDU	S		Month January	Day	Year 2007	12:00 pm <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give s 501 Main Street U	street and number) nit 420		4b. City, Town, 6	or Location of Dea		4c. Co	unty of Death	
	Funeral Director		080-22-7733	7. Age ( M 2□F	n yrs. last birth 80 Yı	Months Davs			, Year)	Cour	olace (State or Foreign htry) York
	/land ow at		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town	or Location				1	0d. Inside City Limits
	e Mar a-f sh tified	ctor	MD Prince G	George's	Laure	el					1X Yes 2 No
	or 28	Director	10e. Street and Number		-	10f. Zip Code		1	0g. Citizer	of What Cour	ntry?
	s 23a		501 Main Street,	Unit 420 12. Was Decedent Eve		20707		(O		USA	on Indian
30	be filed within 72 hours after death with the Maryland Hygiene. ad other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 1 ▼ Widowed 4 □ Divorced	er in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ☒ No Specify: Specify: White						
215-0036	2 hour	ted t	15. Decedent's Edu		16a. D	Decedent's Usual Occu	pation		16b. Kind	of Business/In	dustry
7	ithin 7 ne. nan "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	- 1	Give kind of work done life. DO NOT use retire		vorking			
7	filed within Hygiene. other than " ent, the Med		12th  17. Father's Name (First, Middle, Last)	Ø	Ar	ntique Deal		lame (First, Middle,		tiques	
yland	d be f ental h red of	Be c	Edward M. Stever	ngon				e Vaughan	maideir ou	mamej	
چ	shoul nd Me mark	2	19a. Informant's Name/Relationship (Ty		19b. I	Mailing Address (Stree			r, City or To	own, State, Zip	Code)
, Mar	es 1 and 2 should be of Health and Mental f item 27 Is marked o r other traumatic eve		Adele Gay Russell/	/Daughter	125	Murdock F	Road, Ba	ltimore, 1	MD 2	1212	
saltimore,	Pages 1 and 2 ent of Health nt: If item 27 I ry or other tra		20a. Method of Disposition 1	temoval from State		Disposition (Name of crematory or other place on National	1	Date 9/2007		ion - City or To	
Balt	permit. Pages 1 Department of H Important: If ite any Injury or ot		21. Signature of Funeral Service Licens		00770	22. Name and Addr	ess of Facility	Donaldson	Fune		
	Physician		23a. Part1. Enter the disease, o compleshock, or heart failure. List vily or Immediate Cause (Final disease or condition	ne cause on each line.		ot enter the mode of dy		,	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a			711 001 7	Discuse			1 Year
	Examine	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of	)·					
/	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c								
, 20,	be executed ician and burial-transit										
6876	ficate b physic s the b	dica		d			_				
Hecords, P.O. Box 687 The law requires that the death certificate the has been signed by the attending phys age 2 should be detached for use as the		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death	3 ☐Ectopic pregnand 5 ☐ Other (specify)	су		23d	f. Date of delive	ery Day Year
ב	res that the de signed by the a be detached f		Part II. Other significant conditions co	ntributing to death but	not resulting in t	the underlying cause gi	iven in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
rds	w requires been sign should be	ed by						_   1 🗆 Y	es 21x	No 3∏ Prol	oabiy 4 □Unknown
Vital Records,	: The law recate has been page 2 sho	Completed						24a. Was a autop perfor	sy	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
<u>ra</u>		Be C	25. Was case referred to medical examiner?				26. Place of D	Death (Check only or			2,4110
or <	Physic this ce	To E	1 ☐ Yes 2 ☑ No			ALIEIT SELDOA		Home 5 TResid			fy)
	Ing F		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day 1		ury Wo	ury at ork? ]Yes 2 ☐ No	28d. Describe h	ow injury o	ccurred	
Division	ospital or Attend hours after death uneral Director: , ly filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	y - At home, farr (Specify)	n, street, factory, office		28f. Location (S City or Tow		Number or Run	al Route Number,
	e Hospital of 124 hours at le Funeral Ciletely filled i	dical (		sician: To the best of iner: On the basis of e and manner state	examination and						

State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D35820

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Eclusieur M.D. (4306)

31. Date filed (Month, Day, Year) 14300 Gallant Fox Love #110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day **Physician** -Month LEONARD GEORGE HESS, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore 2(1G) E If Under 24 Hrs Ligre 8. Date of Birth (Month, Day, Year) Sept. 28, 1924 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours MARYLAND 218-14-5132 82 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits 1 ☐ Yes X☐ No Director MARYLAND BALTIMORE BALTIMORE COUNTY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4926 Ridge Rd. 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 🗶 🗓 Ŋo Specify: <u>Ş</u> Specify: XXWidewed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 10 yrs.MTA Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown ၉ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4926 Ridge Rd. Baltimore, Maryland Mohamad S. Diab (Son~in~law) Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Surial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 1-26-07 Baltimore, Md. 4 Donation 5 Dother (Specify) <sup>22. Name and Address of Facility</sup> Lassann Funeral Home 7401 Belair Rd. Baltimore, Maryland 21. Signature of Funeral Service Licensee Lassahn 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SDIV ator /Medical Due to (or as a consequence of) Examiner bronic Obstructive Army Disesse Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Be Completed 24a. Was an autopsy performed? 1□ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janga 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible ink, Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Julia Hughes Dey Month Yeer 8.40 /1 Tanuary 18 200 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Howard County Hospital

5. Social Security Number 6. Sex Columbia
If Under 24 Hrs. 8.
Hours Min. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) Deys Months 1□M 2☑F 577-44-3107 2/11/1925 Puerto Rico Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 1 ☐ Yes 🎗 🔀 No Anne Arundel Severn 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code Puerto Rico 14. Race - American Indian, Black, White, etc. 8532 Pioneer Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Never Married 2 ☐ Married xXYes 2□No Specify: Puerto Rican Specify: Hispanic 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Child Care Provider Child care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Antonio Vega Julia Flores 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a Informent's Name/Relationship (Type, Print) 4751 Ilkleymoor Lane, Ellicott City, MD 21043
toe of Disposition (Name of Date 20c. Location - City or Town, State Julie McCallister/Daughter 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 1 ☐ Buriel 200 Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1/25/07 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approsite the control of the c Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) andwarceday Descere Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 □ Probably 4 Ūnknown 1 Yes 2 No 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 20 No 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of Injury Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27, Menner of Deeth 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be 3 Suicide

/Medical Examiner physician and s the burial-transit or Attanding Physician: death.

**Physician** 

/Medical

10a Stete

MD

Directo

Funeral

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Completed

Be

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

4 Homicide

29b. Signature end title of certifier

31. Dete filed (Month, Day, Year)

29a. Certifier

Examiner

Funeral

Director

death with the Marylenc

permit. Pages i and 2 should be filed within 72 hours after death with the Maryler Department of Health and Mentel Hygiene. Internet if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avant, the Madical Examiner must be notified at

**Physician** 

Saltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 8 After this certificate hes been signed by the attending funerel director, pega 2 should be datached for usa es the funerel director, within 24 hours efter death.

To the Funeral Director: A completely filled in by the f A Hospital of 24 hours e \$

> State Registrar

30 Neme end eddress of person who completed eause of deeth (Item 23a) (Type, Print) Capapally 201-

**JAN 2 4** 

( anny

109 32. Registrar's Signature

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner steted.

29c. License number

7 30641

Wer Mac Road

29d. Date signed (Month, Dey, Year)

January 19 200

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician anuary Robert Avon Howard /Medical 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner 4c. County of Death Baltimore Grenera N/A 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director 218-72-6356 Jun 10, 1936 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importants if items 23a or 28a-f show Importants if items 72 is marked other than "natural", or items 23a or 28a-f show any inJury or other traumatic event, it is Medical Examiner must be notified at Director 1 Xyes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1917 Division Street Funeral 21217 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify. ò Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steamship Trade Association Longshoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Leonard Howard Violet Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta A. Howard 1917 Division Street Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donnin 5 ☐ Other (Specify) 01/19/07 Metro Crematory, Inc. 22. Name and Address of Facility Catonsville, Maryland 21. Inal of Funeral Service Lice Estep Brothers Funeral Service, P. A nter the mode of dy Futaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Box 68760. attending physician pe Physician/Medical as 1 IF FEMALE ase i 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 2 No 1\_ Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No apital: 1 III Inpatient 28a. Date of Injury 2 2 ☐ ER/Outpatient 3 ☐ DOA After this e Hospital or Attending Pl 24 hours after death. e Funeral Director: Atter the 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours aft To the Funeral D completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

49

State Registrar 31. Date filed (Month, Day,

Registrar
DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Gary Hunt 20 35 PM January /Medical 18 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Medical center Baltimore N/A Social Security Number If Under 1 Year | If Under 24 Hrs. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑M 2 ☐ F 213-36-5222 Director Jan. 10,1938 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f sh Examiner must be notified Directo 1 ☐ Yes 2X No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7463 Lawrence Road Funeral 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 → Yes 2 → No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No à Specify 3 Widowed 4 Divorced Specify. 'natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. Years Financial Advisor Prudential marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Hunt ٩ Laura E. Elways 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Renee Svec (Daughter) 21Ave. North St. Petersburg, FL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If Ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ¶☐ Other (Specify) Neuse Friends Cem. 1/23/2007 Goldsboro, NC 21. Signature of Euneral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. X Rea 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the dise se, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -**Physician** Due to (offs a consequence of): resulting in death) /Medical Examiner Division to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division or Vital Records, 1 Yes 2 No 3 Probably 4 € Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No has page 2 autopsy certificate 2 No 1∐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ۴ 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No the 1 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

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completely

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jennifer M. Coughlin, HD

JAN 2 4

and manner stated.

4940

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

Eastern Avenue Baltimore

29d. Date signed (Month, Day, Year)

January 18, 2007

21224

State Registrar 31. Date filed (Month, Day, Year)

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 730 huson 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wyland! Medical Center 142.5 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 1 M 2 NF 6 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified at 1X Yes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 iner must be n filed within 72 hours after death with Smallwood Street Apt 425 21223 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or item edical Examiner Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🌡 ☐ No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates er than "natur the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Baltimore City (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within of Health and Mental Hygiene.

item 27 is marked other than "other traumatic event, the Mer Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Cafeteria Manager 12th grade 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearl Johnson Joseph Wedington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 42B, Department of Health Important: If item 27 any injury or other to once. James W. Johnson-Husband North Smallwood Street, Apt Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of F Durial 2 Cremation 3 Removal from State 4 ☐ Donation = 5 ☐ Other (Specify) 1/25/07 Crownsville Vet Crownsville, Md 21. Signature of Funeral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm ate Cause (Final Physician disease or condition re citing in death) 00000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a conse uence of Examiner The law requires that the death certificate be executed physician and as the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9☐Unknown 9 ☐ Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? Yes 2 No page certificate ) i Sease ind torc 1∐ Yes or Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral D Hospital 29a. Certifier 126 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

7-335

32, Registrar's Signature

Physician		For State Amend #10b-d, Registrar  1. Decedent's Name (First, Middle,			ertificate of	Dodin	2. Date of Death	3. NQ()()()	3. Time of Death
/Medica		ROMEO ELMO	JONES				JAN 1	8 2007	5:45A M
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Funeral Director	1	5. Social Security Number 187–18–6384	. Sex 7. Ago	e (In yrs. last birthda 93 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 04/29/	<sup>(ear)</sup> 1913	Birthplace (State or Foreign Country) N. CAROLINA
>	-	Usual Residence of Decedent  10a, State 10b, County	Baltimore	10c. City, Town or	Location Tows	~			10d. Inside City Limits
f sho		MD -N/P	Datumbre :			CITY -			150 ANNO
Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, it a Madical Examiner must be notified at once.	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	it Country?
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hartr		JANICE R. JON	ES / WIFE		20 WALKEI				21212
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for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	/		23d. Date of Month	f delivery Day Year
ched	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	tatio of douti	JE Other (apeciny)				
1 00	ā.	Part II. Other significant condition	s contributing to death b	ut not resulting in the	underlying cause giv	en in Part I,	23e. Did toba	cco use contribu	te to the cause of death?
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ep ed pin	ed by						24a. Was an	24b. Wer	e autopsy findings available to completion of cause of
lnous z	pieted by						autonsv		to combiguous or crasso or
2 shoul	Completed by						autopsy performe	ed? deat ZNo 1□	th? Yes 2XNo
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s been 2 shoul	Certification: To Be Completed	examiner?  1	28a. Place of Injunction 28a. Place of Injunction 28e. Place of Injunct	ry Year)  28b. Time Injury  ury - At home, farm, c. (Specify)  of my knowledge, def examination and/or	of 28c. Injury M 1 1 street, factory, office	er: 4 Nursing Ho y at k? Yes 2 No	perform  1 Yes 2  h (Check only one)  me 5 Residen 28d. Describe how  28f. Location (Stre City or Town,	ce 6 Other ( injury occurred et and Number of State) se(s) and manner	Yes 2 No  Specify)  If Rural Route Number,  or as stated.
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al Director: After this certificate has been si led in by the funeral director, page 2 should	ledical Certification; To Be Completed	examiner?  1	28a. Date of Injunction the beat 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction 28e. Place of Injunction building, etc. 28e. Place of Injunction aminer: On the basis of and manner sta	y Year)  28b. Time Injury  ury - At home, farm, c. (Specify)  of my knowledge, de of examination and/or ated.	ath occurred at the timestigation, in my of the course of	Nursing Hoy at k? Yes 2 No me, date and place, pinion, death occurred number	perform 1 Yes 2 h (Check only one) me 5 Residen 28d. Describe how 28f. Location (Stre City or Town, and due to the cau red at the time, dat	ce 6 Other ( injury occurred  et and Number of State)  se(s) and manne e and place, and	Yes 2 No  Specify)  or Rural Route Number,  or as stated. due to the cause(s)

rgaret Klein		Please Type or Print in Black Indelible In State of Maryland / Department of For State <b>Amend #6&amp;7 Per FH G863 ৫/১৯:/০</b> ৮ ক	Health and Mental Hygiene
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last)	Reg. No.  2. Date of Death Month Day January 21, 2007  Reg. No.  3. Time of Death 0127 hrs
dicai Exami			b. City, Town, or Location of Death Glen Burnie  Glen Burnie  Glen Burnie  Glen Burnie  Glen Burnie  Glen Burnie  Glen Burnie  Glen Burnie  Glen Burnie
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 216-54-4804 2X F 58 Yrs.	If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or Months   Days   Hours   Min.   march   10, 1948   Country)   MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trammatic event, the Medical Examiner must be notified at once.	Il Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arundel Linthicum  10e. Street and Number  112 Michael Ave.	1 Yes 2 XX No 10f. Zip Code 10g. Citizen of What Country? 21090 United States
s after death wi ural", or items	by Funeral	1 Never Married 2 XX Married Armed Forces? If Yes 3 Widowed 4 Divorced If Yes, Give Year or Dates:	Decedent of Hispanic Origin? (Specify Yes or Nos, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Yes 2xx No specify: Specify: White
36 nin 72 hour e. than "natu dical_Exan	Completed		s Usual Occupation (Give kind of work done st of working life. DO NOT use retired)  16b. Kind of Business/Industry  Apt. Complex
1215-00: d be filed with ental Hygiene arked other t	å	17. Father's Name (First, Middle, Last) Michael J. Lucey	18.Mother's Name (First, Middle, Maiden Surname) Virginia E. Johnson
MD 2. nd 2 should salth and M sen 27 is mare raumatic e	입	John J. Klein (husband) 112 Mi	Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  chael Ave. Linthicum, MD 21090  ion (Name of cemetery, Date 20c. Location - City or Town, State
Iltimore, nit. Pages 1 a artment of He ortant: If its		1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify 21. Cross Icensee 22. N.	Cemetery 1-25-2007 Brooklyn Park, MD
Physician /Medical :xaminer	Examiner	J. Wayne Osterling 1237  J. Wayne Osterling 237  Atherosclerotic Cardiovascular Disconcerning and Atherosclerotic Cardiovascular Disconcerning and Atherosclerotic Cardiovascular Disconcerning 200  J. Wayne Osterling 237  Atherosclerotic Cardiovascular Disconcerning 200  Joue to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  J. Wayne Osterling 237  Atherosclerotic Cardiovascular Disconcerning 200  Due to (or as a consequence of):  Due to (or as a consequence of):  J. Wayne Osterling 237	Between Onset and
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Box 68760, seath certificate be- the attending physicis of for use as the burit	Physician/Med	23b. Was decedent pregnant in the past 12 months?	al death 3 Ectopic pregnancy Month Day Year er (Specify)
Aecords, P.O. The law requires that the cate has been signed by page 2 should be detached.	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	1 Yes 2 No 3 Probably 4 Unknown  24a Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
Vital hysician: this certi	To Be	25. Was case referred to medical examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check only one)  3 DOA Other4 Nursing Home 5 Residence 6 Other:
Vision or Attend fiter death Director: in by the	Certification:	27. Manner of Death  1 ✓ Natural 2 Accident 3 Suicide 4 Hamiside  28a. Date of Injury (Month, Day, Yaar)  28a. Date of Injury (Month, Day, Yaar)  28b. Time of In 28b. Time of In (Specify)	1 Yes 2 No
Di To the Hospital within 24 hours a To the Funeral completely filled	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr (Check only)	ed at the time, date and place, and due to the cause(s) and manner as stated. on, in my opinion, death occurred at the time, date and place, and due to the cause(s)
() E.2 E.8	Me	29b. Signature and title of certifier  CUT OF HOUR A	29c. License number 29d. Date signed (Month, Day, Year)  O.C.M.E.  January 24, 2007
8		PB	treet, Baltimore, MD 21201
St Regist	ate rar	31. Date filed (Month, Day Year) JAN 2 4 2007  32. Registrar's Signature	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Margaret A. Kittrell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Time of Death Month Day January 22, 2007 Medical Examiner 1358 hrs Margaret 4a. Facility Name (if not institution, give street and number) b. City, Town, or Location of Death c. County of Death 4019 Reisterstown Road **Baltimore** 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 8. Date of Birth(MM/DD/YY 9 Birthplace (State of Director Months Davs Hours Min Foreign 214-72-8272 M Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show Examiner must be notified at once. 1 Yes 2 No yes 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene
If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10f. Zip Code 10g, Citizen of What Country USA terston Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces Never Married White etc Yes Widowed 4 Divorced f Yes. Give Year Yes 2 No specify Specify. ģ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industri Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 'harles ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Monroe Woodmere 41e Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) Pages 1 2 Cremation 3 Department of Bartimore, Hd Donation 5 Other Specify 21. Signature/of Funeral Service Licensee Name and Address of Facility Harris Funeral Home Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Intervai failure. List only one cause on each line. Between Onset and /Medical Death Immediata Cause (Final disease a. Hanging Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED physician the burial -AMENDED Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy past 12 months? 2 Fetal death Month Dav Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate Yes 2 V No Yes 2 No 25 Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes ဥ 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: FOUND: Subject hanged self Natural 5 Pending 1 Yes 2 V No Jan 22, 2007 1345 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 4019 Reisterstown Rd, Baltimore, MD (Specify) Townhouse / Rowhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 23, 2007 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Y 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001

07-00488 Pamela G. Littleiohn

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ameia O. Little		1- For State Registrar		cate of Death	iu Meritai r		g. No. 000	7 0171
Physici Medical Exami		Decedent's Name (First, Middle,Last)     Pamela		Littlejohn	ı.	Date of Death     Month     January 18		3 Time of Death
		4a. Facility Name (if not institution, give street and number)			r Location of Dea		4c. County of De	
- J		St. Agnes Hospital	4	Baltimore				
Funeral Director		5. Social Security Number 6 Sex 7. Age 214-72-8798 1 M 2X F	(In yrs. last b	Yrs. If Under 1 Ye.			(MM/DD/YYYY) 9 2 57	Birthplace (State or eign Country) MD
, any		10a. State 10b. County 1	, ,	vn or Location				10d Inside City Limits
Maryland 28a-f show d at once.	to	MD NA	Balt	imore				1X Yes 2 No
vith the Maryland s 23a or 28a-f show s notified at once.	Director	10e. Street and Number 2300 West North Ave		10f. Zip Code <b>21</b>	216	10	g. Citizen of What C	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s or 28s-f shor other traumatic event, the Medical Examiner must be notified at once	Funeral [		ver in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puert		White, etc	
ural",	by	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade comp	leted) 16a	1 Yes 2 No		work done	Specify: 16b. Kind of Busines	Black
5 72 hou n "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+		during most of working life			TOD. KING OF BUSINES	is midustry
within siene.	Completed	12th grade na 17. Father's Name (First, Middle, Last)		Presser				Cleaners
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other tranmatic event, the Medica	Be C	Roosevelt Littlejohn				ie (First, Middle, Ma ne Gwyni		
21, hould be and Men is mar utic eve	2	19a. Informant's Name/Relationship (Type, Print )	1	9b. Mailing Address (Stre	et and Number or	Rural Route Numb	er, City or Town, Sta	ate, Zip Code)
MD sho cealth and 2 sho cealth and 2 sho cealth and iraumati		Florine Love-Mother 20a. Method of Disposition	20b Place	3111 Windo			ore, Md 20c. Location - City	21216
Baltimore, permit Pages I ar Department of Hee important: If ite		1 X Burial 2 Cremation 3 Removal from State	crem	atory or other place)		ŀ	,	,
altin mit Pa partmet poortan ury or		4 Donation 5 Other Specify: 21. Signature u rai Service Licensee	1 1.	It. Zion			Baltimor	
	J.	Myrette K. Jones	<i></i>	22 Name and Address 4300 Wab				d 21215
Physician /Medical		2 a. Part I. English the disease, or complications hat caused the failure. Until only one cause on each life.				or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a conseq		thromboembolism				Death
		Sequentially list conditions,		ses of lower ext	remities			
	Examiner	if any, leading to immediate Due to (or as a consequence Enter Underlying Cause (Disease or injury that initiated						
cuted nd transit		events resulting in death) Last  Due to (or as a consequence of the death)	uence of):					
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8760, rtificate be ing physicias the buri		IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the			Ectopic pregn	ancv	23d. Date of delive Month	ery Day Year
Box 68's death certification he attending ed for use as a	Physician	past 12 months?	ne of death	5 Other (Specify)				Day (ca)
D. B. tr the de by the ached f	Phy	Part II. Other significant conditions contributing to death be	out not result	ing in the underlying cause	given in Part I	23e. Did tob	acco use contribute	to the cause of death?
i, P.O. ires that to signed by	d by					1 Yes		obably 4 V Unknown
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n of Vi	<u>۽</u>	27. Manner of Death 28a Date of Injury	28b	1	ry at Work?	ng Home 5 R	esidence 6 Oth w injury occurred	er
ision Attendir rector: A	ation	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year	"	1	Yes 2 No			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be	y - At home,	farm, street, factory, office t	ouilding, etc.	28f, Location (Str or Town, Sta		Rural Route Number, City
Hospi 24 hour Funer rtely fil		4 Homicide  29a, Certifier 1 Certifying Physician: To the best of my k	nowledge, d	eath occurred at the time, d	ate and place, and	d due to the cause(	s) and manner as st	ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	nation and/or	investigation, in my opinior	n, death occurred	at the time, date ar	nd place, and due to	the cause(s)
	Σ	29b. Signature and title of certifier	1	29c. Licens			29d Date signed (M	I
	1	30. Name and address of person who completed cause of dea	1h (Item 220)	3	IVI. L.		January 19, 200	J /
		Patricia Aronica-Pollak MD. Assistant Me			treet, Baltimo	re, MD 21201		
St Regist	G LC	31. Date filed (North Pay, Yar) 2007 Begistrar's	Signat dre	houts			_	
Regist	ıei			7				

07-00467

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	COALC
arlos Alberto Limerez State of Maryland / Department of Health and Mental H	<del>l</del> vaien

Carlos Alberto L	ime	rez 1- For State Registrar	St	ate of Mary	land /	Depar	tment of ificate of		d Ment	al Hy	/giene	Reg. No.	) N	0 7	0171
Physicia Medical Exami		1. Decedent's Name (F		Car	los A	lbert	to Lime		_		2. Date of De Month January	ath	Year	1	Time of Death
		4a Facility Name (if no 7617 Carissa		n, give street and	number)		4	D. City, Town, or Laurel	Location of	f Death			County of rince Ge		
Funeral		5. Social Security Num	ber .	6 Sex	7. Age	(In yrs. las	t birthday)	If Under 1 Yea	ar If Under	24Hrs.	8. Date of B	- 1		0	ace (State or
Director		215-66-76	72	1 X M 2 F		51	Yrs.	Months Day	's Hours	Min.	Sept		I	Foreign	y)Argentina
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ow any			o. County				own or Location	n							d. Inside City Limits
arylandar	Director	MD F  10e. Street and Number		e George		Laure	ET.	10f. Zip Code				Ina Citiz	on of Mhat		X Yes 2 No
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nwith ms 23 be no	uneral	11. Marital Status	-	12. Was D		ver in U.S.	13. Was	Decedent of His	spanic Origii	n? (Spe	ecify Yes or No			American	Indian, Black,
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rs afte	۵	3 Widowed  15. Decedent's Education		orced If Yes, Give Y		lotod) I 1		res 2 No					Specify W		
72 hou	eted	Elementary/Seconda			(1-4 or 5+		during mo:	Usual Occupated of working life	DO NOT u	nd of wo	ork done ed)	16b. K	ind of Busir	ness/Indu	stry
036	Comple	12					Banker					Ba	nking	ſ	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ပ္ပို	17. Father's Name (Fire		,					18 Mother's	Name	First, Middle,	Maiden 9	Surname)	·	-
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Baltimore, permit Pages I an Department of Hea Important: If iten	ı	21. Signature of Funera	al Service	Licensee			22 Na	me and Address naldson	of Facility	ral	Home	D A	-11 CO11	Plai	.yranu ,
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xaminer		Immediate Cause (Fina or condition resulting in		a. Athero			ardiovas	cular dis	ease		·			_	Death
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n of Vi		1 Yes 2	No	28a. Date	Inpatient of Injury	28	VOutpatient :		y at Work?		Home 5 8d Describe h		ce 6 🗸 C	Other: Sce	ne
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Division spiral or Attent ours after death teral Director: filled in by the	Certification	2 Accident 3 Suicide 6		not be 28e. Pla	ce of Injury	/ - At home	e, farm, street,	factory, office bu	uilding, etc.	2	8f Location (S	treet and	Number o	r Rural R	oute Number, City
E 6 5	Sel	4 Homicide	deterr		)						or Town, S	tate)			
	g	29a. Certifier 1 Certifier cone) 2 Med	tifying Phy lical Exam	ysician: To the be niner:On the basis and manner	of examin	nowledge, ation and/o	death occurred or investigation	at the time, dat , in my opinion,	te and place death occur	e, and di rred at t	ue to the caus he time, date a	e(s) and and place	manner as e, and due t	stated to the cau	se(s)
>	ž	29b. Signature and title	of certifier	$\bigcap \bigwedge$				29c. License	number			29d. Da	ite signed	(Month, D	ay, Year)
			Du	IV				O.C.N	M.E.			Janua	ary 17, 2	007	
		30. Name an a Tress of Susan Hogan N		1				Stroct Delli		2040	24				
Sta	to i	31. Date filed (Month, Date		SSIStant Medi	egistrar's		III Penn	Street, Baltii	more, MD	2120	)T				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** anian /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number Date of Birth (Month, Day, Year) Feb 3, 1936 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Min 213-32-8947 70 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland N/A **Baltimore** 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23s or death with 506 Sanford Place 21217 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ØYes 2 □ No 1954 Baltimore, Maryland 21215-0036 2 f Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ XNo Specify: Black Specify 3 ☐ Widowed 4 ☐ Divorced 1956 "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Baltimore City** Maintenance 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 ie markad other eny Injury or other traumatic event ODEs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wyatt Lance Christine Lance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores C. Lance Wife 506 Sanford Place Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 01/25/08 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery 21. Signature of Funeral Service Lic 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Ent shock, or or the disease, or complications that caused heart failure. List only one cause on each lin not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Clause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 2 2 No 1 ☐ Yes 2 **200**0 Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 000 1 hpatient 2 ER/Outpatient 3 DOA this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation d in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours after the Funaral DI ompletely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

			1 - For State Registrar	State of	Maryland		artment rtificate			and M	lental Hyg	201	7	01721
	g		Decedent's Name (First, Middle	e, Last)			Timeate	OIL	Jeani		2. Date of Deat	eg. Nø. 🕡 l	J /_	3. Time of Death
	Physic		Richard	Lasek							Month	Day	Yeer	7:24 PM
	/Medi Exami		4a. Facility Name (If not institution		iber)		4b. City, T	Town or	Location o	of Dogsth	Jan	4c. County	2007	1 211111
	LXdiiii	101	University of Ma			Cut.						4c. Counts		
	Funeral		5. Social Security Number		7. Age (In yrs. Ia		If Under 1		If Under 2		8 Date of Birth		O Birth	alaen (Stata as Familia
	Director		213-62-4742	1 <b>½</b> □M 2□F	52	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day, Aug. 20	Year)	Cou	
	9		Usual Residence of Decedent								Aug. 20	,1954	Mar	yland
	rylar		10a. State 10b. County		10c. City,	Town or Lo	cation						1	10d. Inside City Limits
	e Ma ta-f	cto	Maryland B	altimore							Dundalk			1 ☐ Yes 2 🔀 No
	ith th	Director	10e. Street and Number				10f. Zip (	Code				og. Citizen of \	What Cour	ntry?
	238		8268 Kavanagh	Road				2	1222			United	l Sta	tes
	r dez	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S	13.	Was Decede	ent of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)			can Indian,
36	or If		1 Never Married 2 Marr	ied types :	2 □ No		1 🗀 Yes 2		Specify:	, raento i	nican, etc.)		ck, White,	etc.
00	72 hours after death with the Maryland natural', or Itams 23a or 28a-f ahow dieal Evanting the political at	d by	3 Widowed 4 Divorced	Year or Da	es: Vietn	am	7	2310	Specify.			Specify	/: W.	hite
5	"nat	Completed	15. Decedent (Specify only highes	's Education it grade completed)		16a. Deced (Give	lent's Usual kind of work DO NOT use	Occupat done du	ion Iring most	of working	ng ·	6b. Kind of B	usiness/In	dustry
12	within lene. than "	E G	Elementary/Secondary (0-12)	College (1-	4or 5+)	lite. L						Balti	.more	Tool
2	ba filed within 72 hours after death with the Marylar ital Hygiene. Id othar than "natural", or Itams 23a or 28a-f ahow avent, the Welfeal Evanting must be pelified at		12 Years 17. Father's Name (First, Middle,	l astl			Machi						mpan	У
aŭ	d ba	Be	Richard A. L						is. Mother		(First, Middle, N		-,	
₹	should be nd Menta markad maric av	2	19a. Informant's Name/Relations			401 14 111					Charlott			
Ma	d2s than trau		Mrs. Diane F.		fe)						Route Number, undalk,			
ē,	1 and Health Iam 27 othar tr		20a. Method of Disposition											21222
ē	Pages nent of int: If it		1 Burial 2 ☐ Cremation		ate Cer	ce of Disponentery, cren						0c. Location -		
Baltimore, Maryland 21215-0036		ļ i	4 □ Donation 5 ☑ Other (Sp 21. Signature of Funeral Service I		St		nislau			1/24	/2007	Baltim	ore,	Maryland
Ba	permit. Departn Imports any inju		hall	or Do	MI	Di	. Name and 1da−Ru 122 W÷	CK F	uner	al H	ome of I dalk, Ma	undalk	, Inc	2.
			23a. Part1. Enter the disease, or	complications that car	used the death.	Do not ente	er the mode	of dying.	such as c	ardiac or	respiratory arre	TATAUG	212	Approximate
	Pnysician :		Immediate Cause (Final	only one cause on ear	an iinge							,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	as a conseque		any	Si	al	chr	un			
b	Examiner				49 4 001100440									
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	cutec	Examiner	Cause (Disease or injury that initiated events	C.										
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9	ng ph	Med	IF FEMALE:	1										
Box	eath certific attending p for use as	an/l	23b. Was decedent pregnant	23c. If yes, outco	me of pregnand		Ectopic preg	ID ADOL				23d. Date	of delive	гу
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7	at the de	Phy	9 Unknown											
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Ý	The I	Col									performe	ad?   de	eath?	pletion of cause of
VITAI	Physician: The law this certificate has I ral director, page 2 s	Be	25. Was case referred to medical examiner?					2	6. Place o	f Death	(Check only one)			
0	this la	e .	1 Yes 2 No	Hospital:		VOutpatient	3□ DOA	Other:	4 🗀 Nurs	ing Hom	e 5 🗆 Residen	ce 6 🗆 Othe	r (Specify)	
	ding P th. After funera	:uo	27. Manner of Death  Satural 5 ☐ Pending	28a. Date of (Month,	njury 28 Day Year) 28	Bb. Time of Injury	28c.	. Injury at Work?			ld. Describe how			
Sic	Attending r death. actor: After by the funer	cat	2 ☐ Accident investigation in	ation			М	1 TYe	s 2 $\square$ No	0				
DIVISION	or Al	Certification:	4 Homicide determin	and 286. Place of	Injury - At home etc. (Specify)	e, farm, stree	et, factory, o	ffice		28	If. Location (Stre City or Town,	et a <i>nd Numb</i> e State)	r or Rural	Route Number,
_	pital ours a aral (			1						1				(1)
	To the Hospital or Attency within 24 hours after death To the Funaral Diractor: complately filled in by the	edicai	29a. Certifier (Check only one) Certifying 2 Medical E	Physicien: To the be xaminer: On the basi and manner	s or examination	adge, death a n and/or inve	occurred at t estigation, in	the time, my opini	date and pion, death	place, an occurred	d due to the cau I at the time, date	se(s) and man	ner as sta	ted. he cause(s)
	o the	- T	29b. Signature and title of certifier	and manifel	stated.			icense n				. Date signed		
	- 5 - 0		Xhol.	MAN			230. 0		433					ay, rear/
1	rl.	-	30. Name and address of person w	be completed	of death (II)	1a) (** =		1 /	(0)		17	an 1º	1 6	00+
0	14		Joanna Price		. 1			P.	Ltin	g /ha	AIN	212	an I	
	Stat	e	31. Date filed (Month, Day, Year)		strar's Signature	ene	71+	DAU	UIN	WU	MD	212	UI	
	Registra	- 4	JAN 2 4 20	No.	· K.	Coarte	· Secretary							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan		artment of H			giene	07 01722
	Physici		1. Decedent's Name (First, Middle, Last,	JBLIN				2. Date of De Month	nath Day	Year
1	/Medic Examin		4a. Facility Name (If not institution, give NORTHWEST HOSPITA	street and number)		4b. City, Town, o	LSTOWN	Death	4c. County	
	Funeral		Social Security Number     6. Security Number	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24			Birthplace (State or Foreign Country)
	Director		220-24-8756 X Usual Residence of Decedent 10a. State 10b. County		by, Town or Lo	L. L.		09/15/	1920	MD  10d. Inside City Limits
	a-fahor Illiadal	ctor	MD BALTIM			DALLSTOWN	١			1 ☐ Yes 2 No
	with the	I Director	10e. Street and Number 8403 CHARLTON RO	AD.		10f. Zip Code	21133		10g. Citizen of W	/hat Country? USA
	er death Itama 2:	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cub		n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race Blac	e - American Indian, k, White, etc.
0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If itam 27 is marked other than "natural", or itama 23a or 28a-f ahow if it itam 27 is marked other than "natural", or itama 21 is natified at or other treumatic avant, the Mardical Examinar man be inclined at	۾ ا	1 🛣 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 🛣 No			Specify	
215-(	thin 72 t e. an "nati	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0_12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most o	f working	16b. Kind of Bu	siness/Industry
Maryland 21215-0036	filed wi Hygien other th	Be Con	17. Father's Name (First, Middle, Last)		NON	<b>E</b>	18. Mother's	s Name (First, Middle	NONE Maiden Sumam	9)
ylan	2 should be filed and Mental Hygi is marked other aumatic avant, I	ToB	ISRAEL	and Colored	LUBI		CEL			BENDER
, Mar	l and 2 st tealth and im 27 is n ther traun		19a. Informant's Name/Relationship (Ty MAX HIGHSTEIN /		1			OWINGS M		
altimore,	Pages 1 and the nent of He int: If itan		20a. Method of Disposition  1 ፟ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, cren	sition (Name of matory or other pla	се) ZION	1/23/2007		City or Town, State ALLSTOWN, MD
Baltir	permit. Pages 1 ar Depertment of Hea Important: If Itam any injury or othe once.		21. Signment of Juneral Service License	. ///	22	Name and Addre	ess of Facility	SOL LEVII	NSON & B	ROS., INC.
	40244		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the deat				~		Approximate Interval Between
in the same	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	TIVEUMO	ALVIS					Onset and Death
	Examiner		Sequentially list conditions,	Due to (or as a conseq	IT K	TIANS	INFE	CTION	,	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):	·				
8760,	cate be executed bhysicien and the burial-transit	al Exa	resulting in death) Last	Due to (or as a conseq	uence of):					
9	artificate ing phys e as the	Medical	IF FEMALE:							
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation of the pregnant at time of degree of the second	Ideath 3□	Ectopic pregnancy Other (specify)	у		23d. Date Mon	e of delivery ith Day Year
<u>a</u>	8 000	ρ	Part II. Other significant conditions con	ntnbuting to death but not res	ulting in the ur	nderlying cause giv	en in Part I.		_	bute to the cause of death?
Reco	he law require e has been si age 2 should t	Completed	DYSPHAG	IR'					osy p rmed? d	Vere autopsy findings available rior to completion of cause of eath?
Vital		Be	25. Was case referred to medical examiner?	lospital:		. Oth	000	1 ☐ Yes   Death   Check only o	one)	□Yes 2NNo
Division of Vital Records,	ding P	tlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur	4 🗀 Nursi		dence 6 Other	
Divisi	2 = = =	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stro	eet, factory, office		28f. Location (: City or Tox		or or Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir.	Medical (	29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the best of my knoner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tire vestigation, in my o	me, date and popinion, death	place, and due to the occurred at the time.	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier	m-ehto	. m.c	29c Licens	se number			(Month, Day, Year)
1	1		30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type,		141 41	RPME	HTA	11 , 1011,
	Sta	te.	MOATH WEST  31. Date filed (Month, Day, Year)	14 05 PIT VAL 32 Registrar's Signa	CENT.			LSTOWN	MO	21133.
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aniend item 7 per fh 9863 1-24-07 vt
State of Maryland / Department of Health and Mental Hygiens 4,02/09/07dhb
Amend #8, 17,19a, perInf, 6864, 2/5/07 TT Amend Item 23e per dr.,6864,02/09/07dhb
ar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** LEAH MARSH 15.24 P M Janualy 22 COOT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Sinai Mospilal Baltimore Baltimore 8 Date of Birth 1/12/1937 9. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 😾 F Months 70 NY 094-30-0361 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a, State 10b. County sa or 28a-f show t be notified at 1 Ves 2 No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA ms 23a 6205 PEARCE AVENUE 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify: **≥** Specify: 3 Widowed 4 Divorced "natural" Completed of Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) OWN HOME HOMEMAKER Botwinick 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental Marsh **BOTWIMICK** MIRSKY abraham SHIFRA ျှ 19a Informant's Name/Relationship (Type. Print)
Jeffrey Brian
YAACOV MARSH / HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6205 PEARCE AVENUE - BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State AGUDATH ISRAEL CEM. 01/23/2007 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) 7 Days **Physician** Perforation /Medical Due to (or as a consequence of) Examiner 17 Days Peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Days Acute Renal physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Mass 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe page 2 ₽ No 1∐ Yes √2☑No Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred After 1. Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifier ۲ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 22 2007 000 hanse 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD nosintal 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Rosina McDonald Μ. 2007 Tanuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Anne Burnie 8. Date of Birth (Month, Pay, Year) Apr. 16,1917 Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs **Funeral** 1□M 2⊠F Months Days Hours Min. 89 217-05-5963 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10h. County 10d Inside City Limits 28a-f show must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō U.S.A. 'natural', or items 23a 72 Burr Hill Drive 21811 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. or other traumatic event, the Medical Examiner ∏Yes 2 ∰160 f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ 3 ₩Widowed 4 Divorced Year or Dates White Completed yellorald, Rosina 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. Own Home 8 N/Ă Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kate Cassell ပ Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau Joseph Dennis McDonald (Son) 72 Burr Hill Drive Berlin Maryland 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 1/25/07 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furferal Service Licenses McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ESTIPATORY DISTIRESS SYNDROME **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Apple requires that the death certificate be executed burial-transit 1 MENTIA Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy for Month Year Day 5 ☐ Other (specify) 4 Pregnant at time of death the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 4 Nnknown 1 ☐ Yes 2 No 3 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 atural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified filled in by

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature a title of 29d. Date signed (Month, Dav. Year) 200 and address of person who completed cause of death (Item 23a) (Type, Print)

Leu Burxue

State Registrar

Medical

31. Date filed (Month, Day,

301 Hospital Drive 32 ARegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Virginia MCCOYMICK 11.50 AM -07 /Medical 4a. Facility Name (ir not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F 215-22-8158 **Director** 01 13/1927 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int. If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ₩es 2 No other traumatic event, the Medical Examiner must be notified To Be Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1215 21229 USA Kevin 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ HO Specify: 3 Widowed 4 ☐ Divorced Specify: BIX 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) reautician Hoir Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LNEICE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) useerogh 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trauonce. 420 N. Denison Balto MD 21229 Sharon J. Cook-Levi 57. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method Disposition 1 Usurial 2 □ Cremation 3 □ Removal from State 221 Kandallston , mD. 07 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P. KE Batto. MD. Z1279 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerati **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a P.0. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Atesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 027716 Mathew m 1-19-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore. MD. 21229. 5411 old Frederick Rd. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JAN 2 4 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylar		ent of Health and	l Mental Hy	giene .	7 01726
			Registrar		Certific	ate of Death		Reg. No. U U	1 01120
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Ne Vin ()es	sie Mit	chell		2. Date of Do	Pay ZOO-	3. Time of Death  II; 00 AM
	Examir		4a/Pacility Name (If not institution, give s	11	4b.	ity Town, or Location of De		4c. County of D	eath
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		nder 1 Year   If Under 24 H	rs. 8. Date of Bi	rth 0.1	Birthplace (State or Foreign
0.2	Director		JT8- LL 4139 1	M 2 F 80	Yrs. Mont	ths Days Hours Mi	n. (Month, Di	19Z6	Country)
	land ow It		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
	a-f she	ctor	M	E	saltimo	re			1 No 2 No
	vith the	<b>Funeral Director</b>	10e. Street and Number	Λ Λ.		Zip Code		10g. Citizen of What	Country?
	leath v ns 23s must	eral	11. Marital Status	HVE., HPO	J.S. 13. Was D	2)21+	(Specify Yes or No	14. Bace - A	merican Indian.
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ▼ Yes 2 □ No If Yes, Give Year or Dates:	1	ecedent of Hispanic Origin? specify Cuban, Mexican, Purs 2 Mo Specify:	èrto Rican, etc.)	Black, W	
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	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)	( 1)				a, Maiden Surname)	
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	1 and 2 s Health an em 27 is u		Helen Mitchell	(Wife)	2048 S	ress (Street and Number or	2. Apt F	E.Balto.,	mD 21217
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	Place of Disposition ( cemetery, crematory	Name of or other place)	Date	20c. Location - City	
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	5		30. Name and address of person who co Ray mond Millio 25			Renstations N	D Z11	7 /	
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		State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 0 7 0	727
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Maryland 21215-0036 to 2 should be filed within 72 hours att th and Mental Hygiene.	other treumstic event, the Medical Examiner must be notified at To Re Completed by Firnaral Director	Robert Louis Stiner Bethel Edna Downs	
Mar nd 2 sh lith and 27 Is m	r treum	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Tamara L. Spies/ Daughter  824 Randolph Drive, Aberdeen, MD 21001	
Baltimore, Maryland 21215 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "ne	r othe	20a. Method of Disposition  1 🖺 Burgal / 2 🗆 Cremation 3 🗀 Removed from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State	
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Ba Perm Depa Impo	any i	21. Sign four of Fune at Environment of Fune at Environment of Fune at Home, P. A.  1317 Cokesbury Rd., Abingdon, Maryland 210	)09
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			For State Registrar	State of Maryla	•	artment rtificate			ind Me		giene ()	07	01728
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	/Medic Examin		4a. Facility Name (If not institution, give st.  LEVINDALE HEBREW F	reet and number)		4b. City, To	own, or L		f Death		4c. Count	ty of Death	
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8760,	certificate be executed thing physicien and use as the burial-transit	ical Ex	resulting in death) Last	Due to (or as a conse	equence of):								
Box 6	death certific e attending p ed for use as	Physician/Med	in the past 12 months?  1 Yes 2 No	ic. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pre						ate of delivionth	very Day Year
٦. Ö	that the ed by th detach		9 ☐ Unknown  Part II. Other significant conditions cont		esulting in the u	nderlying car	use giver	in Part I.		23e. Did to	bacco use co	ntribute to	the cause of death?
ords	law requires that the di as been signed by the 2 should be detached	eted by								1 🗆 Y	es 2□No	3 🗆 Pro	obably 4 Dunknown
Vital Records,	The lay ate has page 2	Compie								24a. Was autop perfor 1 Yes	sy	prior to c death?	opsy findings available ompletion of cause of 2 No
	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1  Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DO4				Check only one 5 Resid		ther (Spec	ofu)
Division of	D e	ertification: T	27. Manner of Death  1/2 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)			ic. Injury a Work?	at es 2 1	2	8d. Describe h			ny)
DIVIS	4 0 0 >	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, factory,	office		2	8f. Location (S City or Tow	Street and Nun n, State)	nber or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in D	edical	29a. Certifier  (Check only one)  Certifying Physical Certifying Physical Examination (Check only one)	ician: To the best of my ker: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred a vestigation, i	t the time in my opi	nion, deat	d place, a th occurre	nd due to the o d at the time, o	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				License		for ord		29d. Date sign		
'	1		30. Name dress of person who cor	mpleted cause of death /It	(TVDa)	Print) 1.6	VIN	645	33 6 N	URSIN	01 4 Horn	22	1007
_		1	BABATUNDE M	. A J A J 32. Registrar's Sig	MJ	21	+34	W	Bti	VEDER	E AVE	NVE	MB 21215
	Sta Regist	и о п	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	of							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 7 per dvr g63 1-300 vt amend items 18,20b,c per fh g864 2-5-07 vt

State of Maryland / Department of Health and Mental Hygiene

State Amned #20c, perFH, g863 1/24/07IT

Certificate of Dooth

Certificate of Dooth 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KPALA 25 **Physician** RNEST 2007 /Medical to M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 7. Age (In yrs. last birthday) II Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) 01 02 Baltimore Levindale Nursing Home Birthplace (State or Foreign Country) **Funeral X**□M 2□F Nigeria Director N/A Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ul Hygiene. other than "netural", or items 23a or 28a-f show vent, The Medical Exeminar insist the notified at 1 □Yes X□No Baltimore Randallstown Director MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Nigeria 21133 ll Cree Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married X Married Baltimore, Maryland 21215-0036 1 Yes 3 No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Business Man 12th grade na 18. Mother's Name (First, Middle, Maiden Sumame) Unk 17. Father's Name (First, Middle, Last) Be it of Health and Mental Nwaokana **Okpala** Pages 1 end 2 should Sidney Okpala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Okpala-Wife 11 Cree Ct., Randallstown, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 111-13 20a. Method of Disposition 20c. Location - City or Town, State. Unk Department of H 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nigeria Okpala Compound Baltimore, MD 21. Signature of Funeral Service Licensee March F/H West Pice. Xala Mar 21215 4300 wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ mouler areider 1 Tes 3 Probably 2 □ No Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 Yes Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 1-2 Natural 28b. Time of Injury 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funarel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 con: 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tems 10e, 7 per fh 8863 1-30-07 vt State of Maryland / Department of Health and Mental Hygiene 2 1 7 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 Month Year **Physician** 2046 2007 Olga Parker /Medical JANUARU 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMOSE SAINT Agnes
5. Social Security Number 6.5 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) O6 07 23 Healthcare Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 XF Director MD 217-16-4468 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Ves 2 No NA Baltimore MD Direct 10e. Street and Number 11 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21225 901 Cheeryhill Road Apt 250 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race · American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Black Specify: ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Balto City Hospital Nurses Aid 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Caroline Morton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Patricia A. Holmes-Daughter 2700 Allendale Road, Baltimore, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 1/27/07 Baltimore, Md Metro Crematory 21. Signature of Fuceral Pervice Licensee 22. Name and Address of Facility
March F/H West ette 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Setween Onset and Death Immediate Cause (Final **Physician** ulmonary embolism unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the control of the cont Examiner Due to for as a consequence off The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Month 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed? 2 No 1 Yes 2 No 1 Tyes Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို s efter deau....ej Director: After this ŏ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: Attanding 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter dea To the Funerei Director completely filled in by th 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ö To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceitifier (m) D47353 ) anualy 20 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agnes Mosp. Hal 900 Caton Avenue Baltimore, talck, mo 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 2 4

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Year Physician Paugh, Jr. January 18, 2007 Dorsey L. 1:25 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Manor Care Nursing Home Rossville Baltimore Co. If Under 1 Year If Under 24 Hrs.

Months Days Hours 8. Date of Birth (Month, Day, Year) June 29,1936 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) 137 M 2 □ F Virginia Yrs West 235-54-6747 70 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a State 23a or 28a-f ahow the Medical Examiner must be notified at Dundalk 1 ☐ Yes 2 No Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 2042 Larkhall Road 21222 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Itame Black White etc. Tyes 2 ☐ No Yes, Give filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 ò Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) Steel Industry 9 Years Pipe Fitter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 2008. Be Dorothy Thompson Dorsey L. Paugh, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dundalk, Maryland (Wife) 2042 Larkhall Road Marie Paugh 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gdns. 1/25/2007 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Service Licensee Dundalk, Maryland 7922 Wise Ave. Q 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, lany, loading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the al 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Hinknown 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 1 ☐ Yes 2 -10 certificate or Attending Physician: 25. Was case referred to medical 26. Place if Death Check only one Be examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 22 No 2 ER/Outpatient 3 DOA Certification: To 1 🗌 Yes this After thi 28d. Describe how injury occurred 28c. Injury at Work? 27. Mann Death 28b. Time of Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Records, P.O. Box 68760. Division of Vital within 24 hours after deat To the Funerel Director: filled in by

> State Registrar

31. Date filed (Month, Day, Year) JAN 2 4

and address of person who comple

29b. Signatura and title of certifier

and manner stated.

led cause of death (Item 23a) (Type-Print)

7601

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Amend #22, perFH	, g864, 1/24/07 T	T Cei	rtificate of	Death	wemai ny	Reg. No.	2007	01732
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Ernest		Robin	son		2. Date of De	eath 18	2007	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give si	treet and number)			or Location of Dea	th		County of Death	0.40p
			Maryland General				timore			NA	
_	Funeral Director		5. Social Security Number 6. Sex 214-26-5345  Usual Residence of Decedent	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ay, Year) -192	9. Birth Cou	place (State or Foreign ntry) Md.
	yland now at		10a. State 10b. County		Town or Lo						10d. Inside City Limits
	e Mar Ba-f sl	ctor	MD NA	Ba	ltimo	ore					1 Aves 2 No
	with the	Funeral Director	10e. Street and Number		. 10	10f. Zip Code	1001		10g. Citi	zen of What Cou	•
	ms 23	neral	1100 North Bolto	2. Was Decedent Ever in U.S.		Was Decedent of H	1201 Hispanic Origin? (S	Specify Yes or No	)-	U.S.A 14. Race - Ameri	can Indian,
920	be filed within 72 hours after death with the Maryland ntal Hygiene. et other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 🟋 No	san, Mexican, Puèl Specify:	to Rican, etc.)		Black, White, Specify: B1	etc. ack
2-0	72 hc " <b>natu</b> i	eted	15. Decedent's Educi (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wo	rking	16b. Ki	nd of Business/Ir	dustry
21215-0036	filed within Hygiene. wher than "	Completed by	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) na		ck Driv	er				altimore
Maryland	t be filed v ntal Hygie ed other t event, th	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		Surname)	
ă Ž	should be and Mental s marked oumaric ev	٩	Ernest Robinson  19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailir	ng Address (Street		Robins		r Town, State, Zii	Code) 21201
	d 2 th a 17 Is		Isabelle Robins	on-Wife							Balto, Mo
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any Injury or other traumatic once.		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Re	moval from State	netery, crei	sition (Name of matory or other pla		Date		cation - City or T	·
Ħ H	permit. Pa Departmen Important: any Injury once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	Kin	-	morial . 2. Name and Addre					own, Md
Ba	Depa Impo any Ir		I IRome	hompson J		4300 Waba		March E e, Balti			<del>21202</del> 21215
	, Si - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		23a. Part1 Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ucute		cardio	8	alcter			Onset and Death
All the	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of:		1				-
		Jer	Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or injury	Due to (or as a nonseque	now of):						
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				·				
68760,	ificate be executed g physician and as the burial-transit	alE		Due to (or as a conseque	nce or):						
687		edical	d.								
Вох	th cert tending r use a		23b. was decedent pregnant	c. If yes, outcome pf pregnand		Ectopic pregnanc	v		2	23d. Date of deliv	-
O. E	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown		Other (specify)				Month	Day Year
, P.O.	that the	/ Ph	Part II. Other significant conditions cont	ributing to death but not resulti	ing in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco u	se contribute to t	he cause of death?
rds	quires an sign	Completed by	Type II Die	abetes N	rele	itus		10,	Yes 2[	□ No 3 □ Prot	pably 4 Unknown
eco	law re as bee 2 sho	plete	tuggetensi	an _				24a. Was			ppsy findings available mpletion of cause of
E E	: The cate h	Соп	00					perfa	rmed? 2No	death?	2No
Z.	siclan certifi	Be C	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1 ☐ Inpatient 2 🗶 EF	R/Outpatien	t 3 DOA Oth	or:	ath (Check only o			
٥٢	g Phy ter this neral d	n: To	27. Manner of Death		8b. Time of			lome 5 ☐ Resident 1 28d. Describe I			ý)
sior	endin eath. or: Afi	atio	1 Natural 5 Pending 2 Accident investigation	(World, Day Teal)	Injury		Yes 2 □ No				
Division or Vital Records,	tal or Att s after de al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tov	Street and vn, State	d Number or Rura )	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical (	29a. Certifier (Check only one) 1 Certifying Physi 2 Medical Examin	cian: To the best of my knowler: On the basis of examination and manner stated.	edge, death n and/or in	n occurred at the til vestigation, in my o	me, date and plac ppinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due t	tated. o the cause(s)
	To the company of the	M	29b. Signature and title of certifier	00.0		29c. Licens			29d. Date	e signed (Month,	Day, Year)
	7		1 Jan	new		D32	2158		11	22/07	
6	2		30. Name and address of person who con	npleted cause of death (Item 2 んしいない タンフ	3a) (Type,	Print) Wall S	t. Ste	407 Be	the	nove. M	D 2 1201
	Sta	te ar	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re		-,	1		, ,	2-1-01

DHMH 17 Rev 1/2001

State Registrar D Roggen

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Old Court Road

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5400

D32844

Suite 108 Randolls town

JANUARY 22

DHMH 17 Rev 1/2001

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Day 3:00 a Johnnie Lee Rumph, Sr. Jan 17 2007 4c. County of Death 4b. City, Town, or Location of Death N/A Baltimore 631 Roundview Road 7. Age (In yrs. last birthday)

For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**⋈**M 2□F Yrs. Director Georgia 260-58-4812 Usual Residence of Decedent Jul 18, 1941 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Itam 27 ia marked other than "netural", or Items 23e or 28a-f ahow other traumatic evant, the Medical Exprinter inst to notified at 1 Yes 2 No **Baltimore** Directo N/A Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 U.S.A. 631 Roundview Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yas 2 M No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Company Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth eny injury or other traumatic evant ODES. Be Carrie Rumph 2 Louis Rumph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 631 Roundview Road Baltimore, Maryland 21225 Christine Rumph Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 01/28/07 Brooklyn Park, Md. Pedar Hill Cemetery & Mausoleum 22. Name and Address of Facility 21. Sign of Funeral Service Licensee Estep Brothers Funeral Service, P. A. hot enter the mode of dyng, swill ascept Rall Importer Mines, 1217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months?
1 Yes 2 No Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 I Inknown 9 Unknown Part II Other significant conditions contributing to death but not respiting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Nnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 2 No 1 🗆 Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner' Other: 4 Nursing Home Hospital: Certification: To 5 Residence 6 □Other (Specify) 1 ☐ Yes 2 🔀 No 1 🗌 Inpatient 2 ER/Outpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie

State

31. Date filed (Month, Day, Year) 2007

and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:10 P <sup>M</sup> JANUARY BLANCHE RESNICK 21 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 3440 ASSOCIATED WAY APT. #206 OWINGS MILLS Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min 1 □ M 2√2 F Yrs. 02/9/1915 91 Director 220-24-5017 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show 1 □Yes 2 No Director MD BALTIMORE OWINGS MILLS 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ral", or Items 23a or Examiner must be r 3440 ASSOCIATED WAY APT, #206 21117 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death onent of Health and Mental Hygiene. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: WHITF 3 X Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY **FURNITURE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SEIRIES **EVA** SH0R MEYER ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 I 3203 TIMBERFIELD LANE - BALTIMORE, MD 21208
te of Disnosition (Name of Date 20c. Location - City or Town, S PAUL ALPERT / NEPHEW 20b. Place of Disposition (Name of MOSES MONTEF TORE) 20a. Method of Disposition 01/23/2007 BALTIMORE, MD ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) WOODMOOR CONG. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** week disease or condition resulting in death) 1 eu mon ca /Medical Dusto (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 □ Nursing Home 5 N Residence 6 □ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident s after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical

within 24 hours at To the Funeral C

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05142 January 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Rothschild 4000 32 Registrar's Signature 31. Date filed (Month, Day, Year) JAN 2 4 2007

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Smith 19 2007 6:45p. M Ricardo 01 Casev 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N/A Baltimore 4601 Sunbrook Ave If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days 1XM 2□F 11 06 95 PA 14 172-76-4742 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State YEYes 2 No Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21206 4601 Sunbrook Ave 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 💥 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Middle School Student 6th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Valarie Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21206 4601 Sunbrook Ave, Baltimore, Md Valarie Boddie-Mother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition W Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 1/25/07 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West alu 21215 Baltimore, 4300 Wabash Ave, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral Director** 

Be Completed by

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

e Hospital or Attending Physician: The law requires that the death certificate be executed the brouss after death. Expension of the trips certificate has been signed by the attending physician and ethored Directors. After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	Immediate Cause (Final disease or condition	BRAIN	TUMOR	2			Onset and Death	
	resulting in death)	Due to (or as a conseq	uence of):				2.5 Y54P	2
iner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b Due to (or as a conseq	uence of):					
cal Exam	that initiated events resulting in death) Last	CDue to (or as a conseq	uence of):					_
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3 □Ectopic			23d. Date of de Month	elivery Day Year	
ed by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacc	. /	to the cause of death? Probably 4 □Unknow	n
Complete					24a. Was an autopsy performed 1 Yes 2 d	death?		е
Be 0	25. Was case referred to medical			26. Place of De	eath (Check only one)			_
To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 □Other (Sp.	ecify)	
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred		
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Street City or Town, St	and Number or F ate)	Rural Route Number,	
Medical Certification:	29a. Certifier Check only one) 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurrent ation and/or investigati	ed at the time, date and pla- ion, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)	_
Me	29h Signature and title of certifier		2	29c. License number	29d. I	Date signed (Mor	nth, Day, Year)	_

D63940 JOHNS HOPKINS

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signatu

DHMH 17 Rev 1/2001

To the I within 2.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** PM 2007 ON Smith Thomas Bernard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **™** 2 □ F 62 05 18 Director 217-40-5291 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f sh notified 1 X Yes 2 □ No NA Baltimore Director MD permit. Pages 1 and 2 should be filed within 72 hours after death with the 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-any injury or other traumatic event, the Medical Examiner must be notificance. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 448 East 22nd Street U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Truck Driver Sanitation Dept. na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Garmon Cooper Mary Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vontessa Smith-Wife Dulaney Street, Baltimore, Md 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 1/30/07 Owings Mills, Md 21. Signature of Funeral Service Licenses March Address of Facility t 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Ischemic **Physician** /Medical Due to (or as a consequence of): Examiner DYDNOYU Gequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burtal-transit one property. Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 4☐Pregnant at time of death 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA ၉ 27. Manner of Death 1. Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

JAN 2 4 20

31. Date filed (Month, Day,

32. Registrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Vear)

Bruke

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

3. Time of Death

PHTIENT KNOWN AS WHLTEL L. SCHERL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene in Program: Insportant: If them 72 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	Location of Death	_	4c. County of Dea	
-	SINAI HOSPITAL  5. Social Security Number 6. Sex 7. Ag	je (In yrs. last birthda)		BALTIMORI If Under 24 Hrs.	8. Date of Birth	9. Bir	N/A thplace (State or Foreign
	216-16-0671 1X M 2 F	82 Yrs.	Months Days	Hours Min.	14726719	24	ountry) MD
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	Location				10d. Inside City Limits
ctor	MD BALTIMORE	BALTIMO	RE				1 ☐ Yes 2 🔀 No
Dire	10e. Street and Number		10f. Zip Code	21200	10g	. Citizen of What Co	
eral	31 STONEHENGE CIRCLE #7  11, Marital Status 12. Was Decedent	Ever in U.S. 13	B. Was Decedent of H If Yes, specify Cub:	21208 ispanic Origin? (Spe	cify Yes or No-	14. Race - Ame	USA erican Indian,
/ Fur	Armed Forces?  1 □ Never Married 2 🕅 Married 1 📉 Yes 2 □ If Yes, Give	No	If Yes, specify Cuba 1 ☐ Yes 2 1 No	an, Mexican, Puerto I Specify:	Rican, etc.)	Black, Whit	e, etc. WHITE
Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	16a. Dec	edent's Usual Occur	ation	16	b. Kind of Business	
nplet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	5+} _   _	ve kind of work done . DO NOT use retired	during most of workir i)	ng		
Cou	17. Father's Name (First, Middle, Last)	2 OW	NER	18. Mother's Name		LIQUOR ST	URE
To Be	SAMUEL	SC	HERR	ANNA	(1 not, madio, ma	den damame)	GOLDBERG
_	19a. Informant's Name/Relationship (Type. Print)		iling Address (Street				
	PAULA SCHERR / WIFE  20a. Method of Disposition	20b. Place of Disp	STONEHENG			LMORE, ML	
	1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, cr	rematory or other place LOH CEMET	' :		WOODLAW	
	21. Signature of Funeral Service Licensee		22. Name and Addre	ss of Facility S(	DL LEVINS	ON & BROS	S., INC.
	Tour Land						, MD 21208
	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each limmediate Cause (Final	ne.	- Control of the Cont	1 1977 - 27	-	,	Approximate Interval Between Onset and Death
	disease or condition resulting in death)  a. Due to (or as	a consequence of):	RATORY	ARRES			
_	Sequentially list conditions,	ARY AV	ltery d	158452			YEARS
sician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	STA6 &	LENAZ	DISEA	45		2+ YEHLS
Exa		a consequence of):					
dica	d						
in/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome					23d. Date of de	livery
	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B Ectopic pregnancy Dother (specify)			Month	Day Year
Completed by Phy	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ed by					1 ☐ Yes	2 □ No 3 □ P	robably 4 Munknown
plet					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Con	OS Was and a state of the state					d? death? No 1 ☐ Yes	2 □ No
o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	ent 2 ER/Outpati	ent 3 DOA Oth	er: 4 Nursing Hor		e 6 □Other (Spe	oife)
Di: T	27. Manner of Death 28a. Date of Inju 1 Natural 5 Pending (Month, Da				8d. Describe how		Sity)
icati	2 Accident investigation 3 Suicide 6 Could not be 200 Blace of ini	ury - At home, farm, s		Yes 2 □No	18f Location (Street	et and Number or R	ural Pauto Numbar
ertif	4 Homicide determined 20e. Place of III	c. (Specify)	succes, reactory, diffice		City or Town, S		urar noute ivaniber,
Medical Certification:	29a. Certifler (Check only one)  1  Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or	ath occurred at the til investigation, in my o	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and du	s stated. e to the cause(s)
Me	29b. Signature and title of tertifier	Þ	29c. Licens	e number 28807	29d	Date signed (Monitor)	h, Day, Year)
	30. Name and address of person who completed cause of d	leath (Item 23a) (Type 1838	e, Print)  GVETPE	Tree Rd=	#245 Bu	Himore, v	AD LIZUE
te	31. Date filed (Month, Day, Year) 22. Registr	rar's Signature	ests!				
ar	JAN 2 4 2007 January	in its later					

Sta Regista

7-00497		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
Briel Latia Charma			0 = 0   7   (
	D.	1- For State Certificate of Death Reg. No. 2	11/11/41
Physician		2. Date of Death	3. Time of Death
Medical Éxamine			1557 hrs
and a	4	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c County of I	)eath
, )		Johns Hopkins Hospital Baltimore	,
Funeral	5	5. Social Security Number 6. Gex	Birthplace (State or
Director		1 0.4. 32 373 Co 1. The second of the second	Country) Wd.
	H	Usual Residence of Decedent	
any	_	10a. State 10b County / 10c. City, Town or Location	10d. Inside City Limits
*		a hd N/A Britimore	1 4Yes 2 No
Maryland 28a-f show datonce.	ا ۃِ	10e. Street and Number 10f Zip Code 10g. Citizen of What	Country?
Mar 28a	<u></u>	g los dies and hamber	A.
h the?			American Indian, Black,
ms 2	e l	11, Marital States	
deat or ite	튀	Armed Forces?    1   Yes   2   No	lack
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ours	<u> </u>	To Decedent's Education (Specify only highest grade completed)  To Decedent's Education (Specify only highest grade completed)  To Decedent's Education (Specify only highest grade completed)  To Decedent's Education (Specify only highest grade completed)  To Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  To Decedent's Education (Specify only highest grade completed)  To Decedent's Education (Specify only highest grade completed)  To Decedent's Education (Specify only highest grade completed)  To Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  To Decedent's Education (Specify only highest grade completed)  To Decedent's Education (Specify only highest grade completed)  To Decedent's Education (Specify only highest grade completed)  To Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  To Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  To Decedent's Education (Specify only highest grade completed)  To Decedent's Education (S	iess/industry
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or thin the delight	티	E O NA NA	-
5-0 led w			
21215-0036 uld be filed within 7. Mental Hygiene, marked other than	8	a unkasun Patricia Thacker	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiers 27 is marked other than "natural", or items 23a or 28a-f she marked other than "natural", or items 12a or 28a-f she in a file of the Medical Examiner must be notified at once	e٦	19a Informant's Name/Relationship (Type, Print ) 19b Mailing Address (Street and Number or Rural Route Number, City or Town,	State, Zip Code)
MD 12 sh th an 127 i		arrecte paceper	
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera Mental Hygiera Prisment of Health and Mental Hygiera Medical Examiner must be notified at once. Injury or other traumatic event, the Medical Examiner must be notified at once.		Zoa. Wethod of Disposition	ity or Town, State
ages nt of		T ABunal 2 Clemation 3 Removal from State (2)	s. Not
Itine pritaine pritaine	+	4 Donation 5 Other Specify:  21 St nature of Funery Service Licenses  22 Name and Address of Faulty  Car 10 and 10	scruce PA
Balti permit Departr Import injury		Carton C. Dungan 1701 He Callot St. Butto. hd. 2	1217
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	
	- 1	b	
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	툂	if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
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Box 68760, e death certificate be the attending physicited for use as the buring	ğΙ	S IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of d	
587 errific ding p	an/	23b. Was decedent pregnant in the past 12 months?  Live birth 2 Fetal death 3 Ectopic pregnancy  Month	Day Year
ath ce	Si	4 Pregnant at time of death 5 Other (Specify)	
Be de the the feet for the feet feet feet feet feet feet feet	اغ	Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	ute to the cause of death?
ords, P.O. Boy wrequires that the deat sbeen signed by the attached to should be detached for			Probably 4 Unknown
irres			ere autopsy findings available
cords law requi	Completed	24a. Was an 24b. W. pri	or to completion of cause of
Reco The law icate has	Ĕ	performed? de	ath? ✔ Yes 2 No
tal Rec			
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death.  The Invertor: After this certificate has been signed by led in by the funeral director, page 2 should be detact	8	examiner? Hospital: 4 Incation: 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6	Other:
f Vit Physic er this	리	1 Ves 2 No 28 Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred	<u> </u>
n of ding Ph	5	27. Manner of Death 28a Date of Injury (Month, Day,Year) 28b. Time of Injury 28b. Time of Injury at Work? 28c. Injury at Work? 28d Describe how injury occurrer 28d D	egurgitated food
Sior Mieud death death ctor:	턣	bolus  Natural  Natural  Natural  Notation  Natural  Notation  Not	or Rural Poute Number City
Divisa pital or At ours after d eral Direct filled in by	<b>[</b> ]	Suicide 6 Could not be 288. Place of Injury - At nome, farm, street, factory, once building, etc or Town, State)	
Spita spita neral fille	Certification:	4 Homicide determined (Specify) subject was on local street Bond St. Baltimore	
			is stated
To the Ho within 24 P To the Fu	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and du and manner stated.	
FSFO	ž		d (Month, Day.Year)
		Nelisia Grassell, MB O.C.M.E. January 19,	2007
		30 N me and address of person who completed cause of death (Item 23a)	
\		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
St	ate	ate 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Regist		18110 A com led Alexander	
	_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SOKOLIS RANCES 5:47 PM JANUARY 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death N/A BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Date of Birth (Month, Day, Year) Months Days Hours Min. 1 M 200 72 217-30-5316 30,1934 Maryland Sept. Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Dunda 1k Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 8004 Wallace Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harold Teresa Crotty 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 8004 Wallace Road Mr. J. Francis Sokolis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/24/2007 Glen Burnie, MD Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility
Duda- Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final SEPSIS days disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of the year) that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1.XInpatient 2 ☐ ER/Outpatient 3 T DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred (Month, Day Year) Injury

the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760 signed by the a Division or Vital Records, page 2 s has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Examiner Physician/Medical ģ Completed Be ٩ Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

the Medical

traumatic

item 2.

permit. Pages Department of Important: If its any injury or o

**Physician** 

Examine

/Medical

than

Pages 1 and 2 should be filed nent of Health and Mental Hyginnt: If item 27 Is marked other

Director

Completed by Funeral

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

M.D.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

RES-000

1 □ Yes 2 □ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

JANUARY 21, 2007

30. Name and address of perion who completed cause of death (Item 23a) (Type, Print)

JENEEN GIFFORD 31. Date filed (Month, Day, Year)

4940 EASTERN AVENUE BALTIMORE, MD 21224

State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Mental Hygien 2 0 7 0 7 4 2  Certificate of Death Reg. No.	
	Physicia /Medica		1. Decedent's Neme (First, Middle, Last)  NO-CHE E SCZEDINSK   2. Dete of Death Month Dey Year 3. 1 Time of Death Month O 20 07 3. 45 P.N.	
, of	Examine	er	4e Fecility Name (If not institution, give street end number)  4b. City, Town, or Location of Deeth  4c. County of Deeth  N/A	
	Funeral Director	-	5. Social Security Number 219-16-4787  1 M 21 F 7. Age (In yrs. lest birthdey) Months Days Hours Min. O6-13-1921  9. Birthplace (State or Foreign Country) Mary Land  Usuel Residence of Decedent	
, Maryland 21215-0020	uth with the Maryland 23a or 28a-f show	Director	10a. Stete Maryland N/A  10b. County Baltimore 10d. Inside City Limits 12d Yes 2□No	
	23a or 2	rai Dire	10e. Street end Number 6207 Marlora Road 10f. Zip Code 21239 10g. Citizen of Whet Country? U.S.A.	
		by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Maried 3 Married 4 Married 3 Marr	
	within ene. then	Completed by	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)  Home Maker  16b. Kind of Business/Industry  Own Home	
	ould be fi Mental H arked oth	To Be C	17. Father's Neme (First, Middle, Last)  Gerson Edwards  18. Mother's Name (First, Middle, Maiden Surname)  Viola McKay	
	id 2 sh ith and if is m treum		19a. Informant's Name/Relationship (Type, Print)  Linda Moore - Daughter  19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)  3813 Marcus Court Monkton, MD 21111	
Baltimore,	Pages 1 ar ment of Heal lant: If Item 2 jury or other		20a. Method of Disposition  1 \( \times \) Burial 2 \( \times \) Cremation 3 \( \times \) Removal from State 4 \( \times \) Donation 5 \( \times \) Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Parkwood Cemetery  20c. Location - City or Town, Slate  1/26/07 Parkville, Maryland	
Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee    22. Name and Address of Fecility   5305 Harford Road   Leonard J. Ruck, Inc.   Baltimore, Maryland 21214	
1	Physician /Medical Examiner		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one ceuse on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	
c 68760,	death certificate be executed ettending physician and effor use es the bunal-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Use to (or as a consequence of).  C. Due to (or as a consequence of):	
s, P.O. Box	as that the death certific igned by the ettending p be detached for use es	Completed by Physician/Medical	y Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Sacral duub, his ulcer Diabetes mellins  1 Yes 2 to No 3 Probably 4 Unknown  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
of Vital Records,	e law requiras that the has been signed by th ge 2 should be detache	mpieted t	or country	
tal	ulclan: The is cartificate ha rector, pege	မှု မြ	1   Yes 2   Mo   1   Yes 2   No   25. Was case referred to medical   26. Place of Deeth (Check only one)	
	hya Bigin	၉	exeminer?    All   Yes   2	
Division	To the Hospital or Attendi within 24 hours attar death. To the Funeral Director: A completely filled in by the fr	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier  (Check only one)  (Check only on	
	To the within 2 Comple	¥	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yeer)  29d. Date signed (Month, Day, Yeer)  29d. Date signed (Month, Day, Yeer)	
	12		30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)  AND J. CHARLES OF BATTURE MD 21204	
<b>*</b>	Stat Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ELOIS 20 2007 annary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MD MEDICAL CENTER BALTIMORE CITY Year If Under 24 Hrs. 8. Date of Birth
Davs Hours Min. (Month, Day, Year) If Under 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 💢 F 57 228-62-0577 Director 09/07/1949 VIRGINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notifled at Yes 2□No N/A MD Director BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3902 WABASH AVENUE, 1B 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: 3 Widowed 4 Divorced BLACK Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical. 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) RAVENWOOD Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT 12TH NURSING HOME 2 YRS CORP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES RABEY HELEN YOUNG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT SATCHELL / HUSBAND 3902 WABASH AVE, 1B, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State DRUID RIDGE CEM. 4 Donation 5 Other (Specify) 01/25/07 PIKESVILLE, MD 21. Signature of uneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heary ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ple years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury 28b. Time of 27 Manner of Death 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar Room S9D10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

22 South G 31. Date filed (Month, Day, Year)

			1 - For Amend #26	Perate of M	ovland 1	/ <b>2476</b> Cer	rment of tificate o	Health and f Death	d Mental Hy	giene Reg. No. 007	01744	
	DIA STATE		1. Decedent's Name (First, Middle, Last	)					2. Date of De Month	ath Day Year	3. Time of Death	
	Physicia /Medic		Marie Catheri	ne Schult	heis				Januar	y 17, 2007	6:29 A M	
	Examin	er	4a. Facility Name (If not institution, give	street and number)			*	, or Location of D	eath	4c. County of Dea		
		щ	2228 Warfield Dr 5. Social Security Number 6. Se		e (In yrs. lasi	t hinth day.	Fore	st Hill	Hrs. 8. Date of Bir	Harford	thplace (State or Foreign	
P ST	Funeral Director			X ☐M 2[ <b>X</b> F / .Ag		Yrs.	Months Day		Ain. (Month, Da	y, Year) C	ountry)	
		ŀ	Usual Residence of Decedent		90				Dec. 2	7, 1916 M	aryland	
	ylanc how	. [	10a. State 10b. County		10c. City, 7	Town or Loc	cation				10d. Inside City Limits	
	a-f e	ctor	Maryland Harford	<u></u>	Abi	ngdon					1 ☐ Yes 2 XNo	
	or 28	Director	10e. Street and Number				10f. Zip Code	9		10g. Citizen of What C	ountry?	
	ath w 9 238		3105 Cardinal Wa			1.2.1	2100			USA 14. Race - Am	- incoloding	
	er de Item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Tyes 2 1		13. V	Yes, specify C	uban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	Black, Whi		
2-0036	urs af	by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	☐Yes 25€N	lo Specity:		Specify:	nite	
Ŏ	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or iteme 23a or 28a-f show event, the Madical Examinar must be multiled at	ted	15. Decedent's Edi			16a. Deced	ent's Usual Occ	cupation	working	16b. Kind of Business		
2	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	5+)			ne during most of ired)	working			
2	ygien ygien her th	Ö	10			F'00	d Serve		Na (751-14 A 41-44)	Meat Compa	any	
Maryland 2121	m = 0 5	Be	17. Father's Neme (First, Middle, Last)  John Paul Kannler						Name (First, Middle Catherine			
<u> </u>	should be nd Menta marked imatic ev	ဥ	19a. Informant's Name/Relationship (T	vne Print)		19h Mailin	n Address (Stre			er, City or Town, State,	Zin Code)	
<u>N</u>	d 2 s ith an 27 ls treui		Cheryl Gallion/ N				25658 No.			540		
ē,	permit. Pages 1 and 2 should by Oppartment of Health and Menta Important: If item 27 is marked eny injury or other treumatic es <u>once</u> .		20a. Method of Disposition	rece		e of Dispos	sition (Name of	ero riera	e, Forest	Hill MD 2 20c. Location - City o	r Town, State	
OH	Pages ent of ht: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1	•	natory or other p y Redee		-20-07	Baltimore,	Maryland	
Baltimore,	arth poorta		21. Signature of Funeral Service Licens				-		Home, P.		- Language Control	
m	Depa Depa Impo eny is		I Kussell Slig			1	317 Cok	runerai esburv R	Home, P. Rd Abina	A. <u>don, Maryl</u> a	and 21009	
	7		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each li	ne	Do not ente	er the mode of o	tying, such as car	diac or respiratory a	rrest,	Approximate Interval Between	
H	Physician		Immediate Cause (Final disease or condition	G	anger	ne	of	Foot			2 months	
*.	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):	11	. /.	Disea			
и	LAdriniei	L	Sequentially list conditions, if any, leading to immediate	b. Pe	riph	eral	Vas	cular	Disee	ي د		
\./	Psit ed	Examiner	b dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
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9	tificating phy as the	ed	-									
Вох	th cer endin r use	an/N	23b. was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pregna	ncv		23d. Date of de		
П	o deal	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□ Unknown			Other (specify			Month	Day Year	
P.O.	es that the death certific igned by the attending p be detached for use as	Phy	9 Unknown		and most records	ina in the	ada shisaa sa sa	ausa ia Bast I	22o Did	tobacco use contribute	to the cause of death?	
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ecords,	w requir been si should	etec							24a. Was			
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5	Physician: r this certifica	ToB	examiner?	Hospital:	ent 2 🗆 Ef	R/Outpatien	t 3 DOA			ndence 6 <b>XXX</b> ner (Sp	Neice's	
9	ding Ph. h. After thi funeral		27. Manne of Death  1 Natural 5 Pending	28a. Date of Inju	ury 2	8b. Time of	28c. l	njury at Work?	28d. Describe	how injury occurred	residence	
Sio	Attending r death. ector: After by the fune	atlo	2 Accident investigation					I Yes 2 □ No				
Division of Vital	7 9 5 5	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of in	jury - At hom tc. <i>(Specify)</i>	e, farm, str	eet, factory, offi	се	28f. Location ( City or To	(Street and Number or F ewn, State)	Rural Route Number,	
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	To the Hospitel or At within 24 hours effer of To the Funerel Direct completely fitled in by	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam one)	niner: On the basis of and manner si	of examinatio	n and/or in	vestigation, in n	ny opinion, death	occurred at the time.	cause(s) and manner a , date and place, and du	ue to the cause(s)	
	ro the Mithin Fo the	Me	29b. Signature and title of certifier					ense number		29d. Date signed (Mor		
	. 21 0		<b>)</b>	MD				D350.	12	January	18,2007	
	Y		30. Name and address of person who	west no	death (Item 2	23a) (Type,	ONZ	Ave.	Bel	Air, Me	18,2007	
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatu	re Alexander	5.1					
Yax	riegist	T CIT	IAN 2. 4. 200	11 8 JE MESSAG.	A State	A STATE OF THE PARTY OF THE PAR	- Comment					

			Please	Type or Prin						-		_	e.		
		For State		State of Ma	arylan					Mental Hy	gien	e	may	0.1	
		State Registrar	o (Eirot Middle I s	int)		Ce	rtificat	e of l	Death	2. Date of De	Reg. No	0.200		3. Time	145 Posth
Physicia		David Alexander Varinski										ear		M	
/Medic Examin		4a. Facility Name (/	f not institution, giv	re street and number)			4b. City,	Town, or	r Location of Death			c. County of	Death	8:20	рш.
3 : <u>- 1 - 2 - 7 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2</u>	N.		st Center				Tows					altimo			
Funeral Director		5. Social Security Number 213-30-2557   6. Sex 1 M 2 F   7. Age (In yrs. last birthday)   1f Under 1 Year   1f Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   Nov. 11, 1933											place (State ntry)		
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3a or			thony Ave	nue			212				U.S		at Ooui	itiy:	
death	Funeral	11. Marital Status		12. Was Decedent B	Ever in U.	S. 13.			ispanic Origin? (S an, Mexican, Puert	pecify Yes or N		14. Race - Black,			
72 hours after death with the Maryland 72 hours after death with the Maryland natural", or items 23a or 28a-f show likal Examiner must be notified at	by Fu	_	ied <b>XX</b> Mamied	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	10	j	1 ☐ Yes		Specify:	o 1 (10d11, 010.)		Specify: [			
hour hour atural		3 Widowed	15. Decedent's E	<del></del>		16a. Dece	edent's Usua	al Occup	ation		16b. ł	Kind of Busin			
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ntai H ed oth	Be	17. Father's Name							18. Mother's Nan						
should nd Me mark imatic	_C	19a. Informant's N		Varinski (Type. Print)		19b. Mail	ing Address	(Street	Josephir and Number or Fit				ate. Zir	Code)	
and 2 sauth au 127 is er trau		Carolyn	Varinski			1			Avenue,						06
of He		20a. Method of Disp		Removal from State	20b. P	lace of Disp emetery, cre	osition (Nar ematory or o	ne of ther plac	ce)	Date	20c. L	ocation - Ci	ty or To	own, State	
t. Pag tment tant: I		4 ☐ Donation	5 Other (Speci	fy)	Du.	laney	Valle	у	Jan	25 2007	T	imoniu	m,	Mary1	and
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F	uneral Service Lice	nsee		2	22. Name ar 5 / 1 5 D	d Addre	ss of FacilityMil ir Road,	ler-Dip	pel	Funer	al	Home,	
	_	23a. Part1. Enter t	the disease or con	nplications that caused	the death							Maryı	and	Approxima	ate
Physician		Immediate Cause disease or condition	(Final	one cause on each lir	ne.	205	25					14		Onset and	
/Medical		resulting in death)	•	Due to (or as	a consequ	ence of):	) p i		organ	( -1	1.6	,		1 0	7-3
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t the c by the	hysi	9 ☐ Unknown		9□Unknown					-						
The law requires that the death certificate tee has been signed by the attending physoage 2 should be detached for use as the	by P	Part II. Other signi	ficant conditions	contributing to death bu	ut not resu	ılting in the	underlying c	ause giv	en in Part I.			use contrib			
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ne faw has b ge 2 sl	Completed									24a. Was		pric	re auto or to co ath?	psy finding mpletion of	s available cause of
		25. Was case refe	rred to medical						00 Pl1 P	1□ Yes	2 🗗 N		Yes	2□ No	
Physician: The far this certificate has al director, page 2	То Ве	examiner? 1 ☐ Yes 2 ☑		Hospital: 1 ☐ Inpatie	nt 2	ER/Outpatie	ent 3 DC	Oth	er: 4 Nursing H	ome 5 Res		6 POther	(Specif	60// A	20100
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ttendi death.	icati	2 Accident	investigation 6 ☐ Could not be	e 280 Place of init	Inc. At ho	mo form o	M tract factor		Yes 2 □ No	201	(011-		-		
l or Al after of Direc	Certification:	4 Homicide	determined		o. (Specify	me, tarm, s	treet, factory	, office		28f. Location City or To	(Street a wn, Stat	ind Number te)	or Rura	ul Route Nu	mber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director;		29a. Certifier	1 Certifying P	hysician: To the best	of my kno	wledge, dea	ith occurred	at the tir	me, date and place	e, and due to the	e cause(	s) and mann	er as s	tated.	
the Hone Hone Hone Hone Hone Hone Hone Hon	Medical	(Check only one)		miner: On the basis of and manner sta	ated.	uon and/or i	nvestigation	, in my c	pinion, death occu	irred at the time	, date ar	nd place, an	d due t	o the cause	·(s)
To To	2	29b. Signature and	title of certifier	han lle	ly	, up	290	Licens	e number	-	29d. D	ate signed (	Month,	Day, Year)	007
.1.		30 Name and add	ress of nerson who	completed cause of de	eath (Item	23a) (Tupo	Print\	10	0		0 9	- YC U/4	7	-	•
H		W, A. R		G BMC	679	) /	Cho	160	e number 2 53 35 54. Bo	elts. o	Nd	212	0 %		
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Registr	ar			ar											

			For State	State of Ma	aryland / [	Department of Certificate of			lental H	6	200	7	01746
			Registrar  1. Decedent's Name (First, Middle,	Last)		Certificate C	Dean	1	2. Date of D	Reg. No.			3. Time of Death
	Physici			,		Wort	hu		Month	Day	2 200	ear	12 18 M
	/Medic Examir		Mary 4a. Facility Name (If not institution,	give street and number)		4b. City. Town		n of Death	Lanuc	41 -1	County of		1213
	Exami	iei	St Agnes	Hospita	1	Bal-	nmo	ore_			,		
_	Funeral		0 100		(In yrs. last bir	thday) If Under 1 Ye		er 24 Hrs.	8. Date of E (Month, L	Birth	9	. Birthp	lace (State or Foreign
	Director		241-72-8256	1 □ M 2 <b>X</b> □ F	62	Yrs. Months Day	s Hours	Min.	10		44	Coun	NC
	P.		Usual Residence of Decedent		10. 0. 7								
	aryla	_	MD NA		10c. City, Tow Balti							1	0d. Inside City Limits  X□Yes 2□No
	98 - 68 M	ecto			24252								
	with th		10e. Street and Number			10f. Zip Cod	1215			10g. Citi	zen of Wha		itry?
	within 72 hours after death with the Maryland ene. Then "neturel", or flems 23e or 28a-f show na Medical Examiner must be notified at	Funeral Director	3811 Hilton R	12. Was Decedent E	Ever in 11 S			Origina (Co.	noify Vac as N	10	14. Race -		an ledice
	ften de l'action d	ůn	11. Marital Status  1 Never Married 2 Marrie	Armed Forces?		13. Was Decedent of If Yes, specify C	uban, Mexic	an, Puerto	Rican, etc.)	40.		White,	
36	irs af	by	Widowed 4 Divorced	If Yes, Give Year or Dates:	.0	1 ☐ Yes 2 🛣 N	lo <i>Specil</i>	fy:			Specify:	В	lack
21215-0036	2 hou	ted	15. Decedent's	Education	16a	Decedent's Usual Oc	cupation			16b. Ki	nd of Busin	ness/Ind	dustry
215	n n	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed)  Cotlege (1-4or 5	4)	(Give kind of work do life. DO NOT use ret	ne during me ired)	ost of work	ing				,
21;	d with	Completed	12th grade	na	"	Regist	ered	Nurs	se		Hosp	pita	al
P	al Hy toth	Be (	17. Father's Name (First, Middle, L.	est)			18. Mot	her's Name	First, Midd	le, Maiden	Sumame)		
<u>a</u>	Ment Ment rkee	2	Jerry McMilla	n					omart				
Maryland	2 sho and is m	h 3	19a. Informant's Name/Relationshi			. Mailing Address (Stre							Code)
	and ealth m 27	li j	Valeria McMil	lan-Marti		40 Pine S				-	28		
or o	Peges 1 and 2 should be filed within 72 hours after death with the Marylan near of Heath and Mentai Hygiene. In: If term 27 is marked other than "naturel", or frems 23s or 28s-f show iny or other traumatic event, the Madical Esaminer must be notified at		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3	□Removal from State		Disposition (Name of ry, crematory or other p	lace)		Date		cation - Ci		
<u> </u>	T E T	Ш	4 ☐Donation 5 ☐ Other (Spe	city)	Pa	ntherford	l j	1/26,	/0/	кеа	Spr	ing	s, NC
Baltimore.	permit. Peges 1 ar Depertment of Hea importent: if Item eny injury or othe		21. Signature of Funeral Service Li	censee	1	22. Name and Ad	H We	st Ave,	Balt	imor	e, M	đ	21215
			23a. Parri. Enter the disease, or c	omplications that caused	the death. Do								Approximate
	Physician		shock, or heart failure. List o	1									Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. //CUTE Due to (or as a	TULM a consequence	DONARY C	m Bo	LUS				-	10 minutes
	Examiner			BILLATE	nai Da	DONARY E	20000	200	c				3 weeks
		Jer	if any, leading to immediate		a consequence	of):	44 4 37 1	333	•				5 weerd
	cate be executed physicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								Н	
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68760.	ate b hysic the b	dical	'	d				•					
ý	entific Jing p	Me	IF FEMALE:	20- 16									
Box	Jeath certific ettending p	lan/	23b. Was decedent pregnant in the past 12 months?	12 months?   Live pirm   2   Felai death   3   Lectopic pregnancy   Month								ry Day Year	
		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 No 4 Pregnant at time of death 5 Other (specify)									•
0	that the post of t		Part II. Other significant condition	s contributing to death bu	ut not resulting in	n the underlying cause	given in Par	t I.	23e. Did	tobacco u	se contribu	ite to th	e cause of death?
ds	signes Id be	d by	metastatic	•		inoma			10	Yes 2	No 3[	_ Proba	ably 4 Unknown
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rthey Mary	The lew sete hes b page 2 sl	Completed							aut	opsy formed?	prio dea	r to con	osy findings available apletion of cause of
$\leq \frac{\pi}{6}$	ilcian: Th certificete rector, pag	ပို	25. Was case referred to medical						1 ☐ Yes	2 No			2 🗆 No
<u> </u>	Physician: this certific ral director,	00	examiner?	Hospital: 1  Inpatie			)than	-1-1	Check only				
20	ding Phys h. After this funeral di	٦: <u>۲</u>	1 ☐ Yes 22 No 27. Manner of Death	28a. Date of Injur	y 28b.	Time of 28c. In	4 [_] 1		me 5 Res 28d. Describe			(Specify	)
20	ding th: Afte	ş	Natural 5 Pending	(Month, Day	Year) I		/ork? □Yes 2[						
2.8	Attending r death. ector: Afte	i ca	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Inju	ıry - At home, fa	irm, street, factory, offic	:e		28f. Location	(Street and	d Number (	or Rurai	Route Number,
8	s afte	Certification:	4  Homicide determin	building, etc	. (Specify)				City or T	own, State)			
3	Hospital (24 hours a)     Funeral Dietely filled i		29a. Certifier 12 Certifying	Physicien: To the best of	of my knowledge	e, death occurred at the	time, date a	and place, a	and due to the	e cause(s)	and mann	er as sta	ated.
	To the Hospital or Attentwithin 24 hours after detail to the Funeral Director Completely filled in by the	edical	(Check only 2 Medical E	caminer: On the basis of and manner sta	ted.	d/or investigation, in m	y opinion, de	eath occurr	ed at the time	a, date and	place, and	due to	the cause(s)
	P T T T	Σ	29b. Signature and title of certifier			29c. Lice	nse numbe	r		29d. Date	signed (A	Month, L	Day, Year)
	2		Polume C	Duni Con	an	D	2264	6		JAMI	QRV.	19.	2007
	, U		30. Name and address of person w	no completed cause of de	eath (Item 23a)	(Type, Print)		0			****	-	
				yder m.D. 9	200 South	(Type, Print)	nue	Balt	imere	, ma	rylar	nd	21229
	Sta Registi		31. Date filed (Month, Day, Year)	JZ. I togis	r's Signature	H. Knack	,				V		
	negisti	aı	JAN	J = LYUI for	أكلن الشديد تعهيدات	J. P. J. M. P. C.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Registrar

For Amend #19b Per State 36 Many/2004 O Penartment of Health and Mental Hygiene Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O1 1<sup>Day</sup> **Physician** 2007 Lucille Wise 10:05a.M Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6658 Shelly Road Apt Cl87 Glen Burnie Anne Arundel Year) 33 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 10 11 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 □ M 2 🔀 F Hours 73 Yrs MD Director 218-28-8061 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits than "naturai", or Items 23a or 28a-f show he Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 6658 Shelly Road Apt C187 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Black Specify: Specify: ģ 3 ☐ Widowed 🏕 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Smithsonian Elementary/Secondary (0-12) College (1-4or 5+) the Institute 12th grade Clerk lyr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If item 27 is marked of Phillip D. Nelson Rose Mae Bell 19b. Mailing Address (Street and Number or Runn Boute Number & City or Town State, 27 193 19a. Informant's Name/Relationship (Type. Print) Michelle Hilson-Daughter Baltimore, Md 8811 Church Lane, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 1/26/07 Injury Baltimore Co, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West any ir 4300 Wabash Ave, 21215 Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 ☐ Yes 2 TNo 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 I Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 2 No 1∐ Yes 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 □ DOA Certification: To funeral dir After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 2 Accident within 24 hours after www.

To the Funeral Director: After with filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) D0016263 30. Name and address of death (Item 23a) (Type, Print) RD , GLEN BURNIE. 31. Date filed (Month, Day, Year. State Registrar 200

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM 18 per FH (283 1/24/07 LS)
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** ROSETTA WALKER 00.05aM 07 /Medical Jeinnay 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner blospital of N/A Ennai Ballinore Ballinore Cuta If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2**∑** F 83 Director 220-03-4879 03/28/1923 MARYLAND Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at N/A MD BALTIMORE CITY 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4303 GROVELAND AVENUE USA Funeral "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify δ Specify: BLACK 3 □Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6ТН HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE MURRY MARGARET **EDCT EN** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID WALKER /SON 3411 SPRINGDALE AVENUE, BALTIMORE, MD 21216 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Important: If It any Injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) DRUID RIDGE CEM. 01/27/07 PIKESVILLE, MD ★Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, Inter the lisease, or complications that caused the position. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death Cause (Final **Physician** Due to ( r as a consequence of): Day dise or condition resulting in death) /Medical Examiner Acidosi Day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1, Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of Injury at 28d. Describe how injury occurred Certification; Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD January 20, 2007 KES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Bhawna MD Sinai Gupta 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN24 Registrar

			1 - For State Registrer	State	of Marylan		artment of H		Mental Hygie	ene2 () () 7	01749			
	Physici	an	Decedent's Name (First, Middle		ct Ashby	walte	r, Jr.	2. Date of Death Month	Day Year	3. Time of Death				
	/Medic Examir		4a. Facility Name (If not institution				4b. City, Town, or	Location of Dea		19, 2007 4c. County of Dea	10:30 P			
	LAdiiii	eı	1202 Middle Ri		,			le River		Baltimo				
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr			thplace (State or Foreign ountry)			
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	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits			
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	r 28a	Director	10e. Street and Number				10f. Zip Code	MICC		g. Citizen of What C	ountry?			
	th with	al D	1202 Middle Ri	ver Road			21:	220		United St	tates			
	dea	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of Hi	ispanic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Race - Am- Black, Whi	erican Indian,			
36	or it	by Fu	1 Never Married 2X Marri	ed 1X Yes If Yes, G	2 □ No		1 ☐ Yes 2 ☒ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify:	10, 810.			
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2	ould be filed v Mental Hygie wrked other t	Be (	17. Father's Name (First, Middle, I					18. Mother's Na	ame (First, Middle, Ma	uden Surname)				
<u>  Yaa</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. ie marked other than "naturel", or items 23a or 28a-f ehow eumatic event, the Madical Examinar must be notified at	٦ <sub></sub>	Herbert Ash	<del>-</del>	s, Sr.				Kathleen					
Maryland 21215-0036	permit. Pages 1 and 2 should by Opportunit of Heelih and Menta Important: if item 27 is marked any injury or other treumatic and one of the process.		19a. Informant's Name/Relations! Mrs. Janis M.		life)				Rural Route Number, ( .oad Middl		Zip Code) 21220			
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ı			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death Onset and Death											
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UC	or Attending Phy ter death. Irector: After thi by the funeral of	<u>io</u>	27. Manner of Death  1		of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how	injury occurred				
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	To the Hoe within 24 ho To the Fund completely f	edical	one) 2 Medical E	xaminer: On the b	asis of examina ner stated.	tion and/or inv	estigation, in my op	onion, death occ	urred at the time, date	and place, and due	to the cause(s)			
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	1/2	1 n. ()		29c. License		29d	. Date signed (Mont				
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10	+1)		30. Name and address of person v 5601 60 60 31. Date filed (Month, Day, Year)	Raven:	se of death (Item	1 23a) (Type,	Balta	). M	12/2/2	239				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 20, Gladys Marie Yarbrough January 2007 16:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2X F 80 215-22-6522 Jul. 27, 1926 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Director Maryland Harford Churchville 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 3162 Aldino Road 21028 13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ☐Yes 200 No fYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: Specify à If Yes, Give Year or Dates: 3 SWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerical U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mallie Victorine Kinder William Wagg Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn H. Yarbrough/Son 137 Hopkins Rd., Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Harford Memorial Gdn | 1-24-07 Aberdeen, Maryland 22. Name and Address of Facility
McComas Funeral Home, P. A.
1317 Cokesbury Rd., Abingdon, Maryland 21009 23a Part1 Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death erebro Vascular Immediate Cause (Final WK disease or condition resulting in death) Due to (or as a consequence of): > loyrs OPD Socuentially list can ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ner Exam resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 No 9 Unknown 9 ☐ Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part l. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Knunown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Pface of Death | Check only one Hospital: 1 X Inpatient 1 ☐ Yes 2 📉 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge ideath conumed at the time, date and place, and due to the cause(e) and marker as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifier Medicai

uires that the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transit Box 68760, P.0. Records, been si should I this certificate of Vital within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. Division the Hospital or Attending

**Funeral** 

Director

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filed within 7 Hygiene.

12 should be filed w h and Mental Hygier 7 ie marked other tt

Depertment of Heelth a important: if item 27 is eny injury or other tre auce.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

prough,

State Registrar

29b. Signature and title of certifier

amridy

31. Date filed (Month, Day, Year)

la man

10N 2 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Milhani My 1106 1

32 Registrar's Signature

10

29c. License number

D32-609

evolution St. Havrede Grane MD21078

29d. Date signed (Month, Day, Year)

		_	For State Registrer	State of Ma	arylan		artmen tificat				F	Reg. No.	07	017	51
П	Physici /Medic	5.7	Decedent's Name (First, Middle, Last	)		_					Date of Dea Month	Day	Year	3. Time of	
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	3a or	O E	1552 Elrino Stree	t			212	24				U.S.A.			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: If item 27 is marked other than "natural; or items 23e or 28e-f show any figury or other traumatic event, I'm Medical Examinal must be notified at ance.	by Funeral Director	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2 Zu If Yes, Give X Year or Dates:	Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent If Yes, specify 1 □ Yes 2 ☑ Year or Dates:				spanic Origi n, Mexican, Specity:	in? (Specif Puerto Ric	y Yes or No- an, etc.)		14. Race - American Indian, Black, White, etc.  Specify: White		
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Maryland 21215-0036	iould be fi Mental H harked of	To Be	Frank Zimmerman  18. Mother's Name (First, Middle, Last)  Blanche Harmon												
Mar	d2 sh th and 17 is n traun		19a. Informant's Name/Relationship (T)  Vernon W. Zimmer		her	1	•							ryland	21050
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Funeral	Г	Social Security Number     6. S		ist birthday) If Un Monti	der 1 Year If Under 24 H	s. 8. Date of Birth	9 Birthr	lace (State or Foreign
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pu *	]	Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Location				0d. Inside City Limits
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item item	i.	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No		cedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- arto Rican, etc.)	14. Race - Americ Black, White,	
rs att	by	3. Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	s 2⊠ No Specify:		Specify: 10	hite
Pon non	ed	15. Decedent's Ed		16a. Decedent's U	sual Occupation	14	6b. Kind of Business/In-	duetor
21215-0036 ad within 72 hours at gigne. er than "neturef, or the Medical Exami	Completed	(Specify only highest gra	de completed)	(Give kind of life. DO NO	work done during most of w	rorking		•
212 I with ione ione	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Secretary		Tri G	AS
A STAND	Bec	17. Father's Name (First, Middle, Last)		,		ame (First, Middle, Ma	aiden Sumame)	
Maryland of 2 should be file th and Mental Hy 27 is marked oth	To B	JAMES		Leas	c AN	10	Ta	005
Baltimore, Maryland 21215-0036  sernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mantal Hygiene. mportent: if item 27 is marked other than "neturel", or liems 23s or 28s-f show my hijury or other traumatic event, the Medical Examinar must be notified at most.		19a. Informant's Name/Relationship (	Туре, Print)	19b. Mailing Addr	ess (Street and Number or I			
Mind 2		MARY ANN AST	AritA - drughter	24055	Arrows PoiN	+ Pa Dres	VDALK MI	21219
s 1 and 1 Heal		20a. Method of Disposition	20b. Pla	ace of Disposition (/	Vame of		Oc. Location - City or To	own, State
Baltimore, bernit. Pages 1a Department of He mportent: if item my injury or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)	Hemoval from State	-Shore (	rematory 1-	17-07C	AMBRIDGE	- Marcala 1x
Baltim bemit. Pag Department Importent: eny injury o		21. Signature of Funeral Savice Licer			and Address of Facility	1. 0.0	1000	- Charles
Depa Depa Impo	1	1/1/2-		Char	os. Itighlas	IN IND LI	Baits HI	07712711
		23a. Part1. Enter the disease, or com	plications that caused the death.					Approximate
Dhysisian		shock, or heart failure. List only	one cause on each line.	1	11.1.0	Accord.	:	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque		rdiovascula	Discusse		
Examiner			Due to for as a conseque	siles oi).				
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of).				
ansit	듄	cause. Enter Underlying Cause (Disease or injury that initiated events						
D, exec n and ial-tra	Examiner	resulting in death) Last	C. Due to (or as a conseque	ence of):				
68760, ficate be executed physician and a	cal		d.					
68 ifficat g phy as th								
BOX 6 eath certific ettending p	S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan-				23d. Date of delive	ırv
death	Ca	in the past 12 months? 1 □ Yes 2 ☒ No	1 Live birth 2 ☐ Fetel of 4 ☐ Pregnant at time of dea		pregnancy (specity)		Month	Day Year
P.O.	hys	9 □Unknown	9□ Unknown					
of Vital Records, P.O. Box 68 Physician: The law requires thet the death certifica r this certificate has been signed by the ettending pr rail director, page 2 should be detached for use as it	by Physician/Med	Part II. Other significant conditions c	ontributing to death but not result	ting in the underlyin	g cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
rds quire n sig	D D	Chronic obstr	active Pulmona	ary Dise	254	1 🗆 Yes	2 □No 3 Prob	ably 4 Unknown
O y y day	Completed		, ,			24a. Was an	24h Were auto	psy findings available
He la	E G					autopsy	prior to cor	npletion of cause of
T: T		25. Was case referred to medical				1 □ Yes 2 €	₹No 1 ☐ Yes	2₽ No
Sicia sicia cert	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3□	Other	eath Check only one		
P P P P P P P P P P P P P P P P P P P	<u>ان</u>	27. Manner of Death		28b. Time of	DOA 4 Nursing  28c. Injury at	28d. Describe how	ce 6 ☐Other (Specify	")
O ding	텵	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury M	Work? 1 ☐ Yes 2 ☐ No		, , ,	
DIVISION OF VITAL RECORDS, if or Attending Physician: The law requires tafer death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne, farm, street, fact	ory, office	28f. Location (Street	et and Number or Rura	l Route Number.
DIV after after Dire	ert	4 Homicide	building, etc. (Specify)			City or Town,	State)	
UNISION Of VITAI RECORDS, P.O. BOX 68 To the Hospital or Attending Physician: The law requires thet the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending phycompletely filled in by the funeral director, page 2 should be detached for use as it	alc	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my knowl	ledge, death occurre	ed at the time, date and place	ce, and due to the caus	se(s) and manner as et	ated.
S Ho 24 h Fu letely	edical	(Check only one) Medical Exam	niner: On the basis of examination and manner stated.	on and/or investigati	on, in my opinion, death occ	curred at the time, date	and place, and due to	the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	11.		29c. License number	290	I. Date signed (Month, I	Day, Year)
		V/ 1/11/41	Copronh.	MA	DOG 4428	2   ,	1/16/07	
17		30. Name and address of person who	completed cause of death (Item 2	23a) (Type, Print)			/ . 6/ 0 /	
7 1		Claude Vinnou	112: 111	10 Backs	long Pt Ry	OFFERD	MD 2165	-//
Sta	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signatu	ire _	VICT IN THE	101.17	1/2/65	7
Regist		JAN2 4 2007	See &	best				

			1 - For State Registrar	State of Marylar	nd / Depa	artment of I	lealth and Death		ien@ () () 7	01753
	Dhyaisi		1. Decedent's Name (First, Middle, Last)					Date of Deat     Month	h Day Year	3. Time of Death
	Physici /Medic		Helen Virginia Burl	ce AKA: He	elen Vi	rginia B	urck	January		7:25 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Dea		4c. County of Dea	th
			College View Center	•		Frederic	k		Frederick	
	Funeral		<ol><li>Social Security Number 6. Sex</li></ol>		•	If Under 1 Year Months Days	If Under 24 Hi		9. Bir	thplace (State or Foreign
r.K.	Director		214-10-48/5	93	Yrs.	Mortana Bayo	110010		, 1913 Mar	vland
	pu .		Usual Residence of Decedent  10a. State 10b. County	100 0	ty, Town or Lo					1,47=p;"
	anyla sho	5	Tod. State	100. 01	ty, TOWIS OF LC	cation				10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	Ba-f	Directo	Maryland Frederick	Fred	erick					
	vith ti	ä	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	ountry?
	23e	æ	700 Tollhouse Avenu		_	21701			JSA	
	er de Item	Funerai		2. Was Decedent Ever in U Armed Forces?		Was Decedent of it If Yes, specify Cub	Hispanic Origin? ( an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
36	s aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No WW If Yes, Give	TT &	1□ Yes 2X No	Specify:		Specify:	• •
Ş	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23e or 28e-f show fre Madical Exercilier must be notilied at		15. Decedent's Educ	Year or Dates: Kore	1	dent's Usual Occup	ation			nite
Ċ	n 72	Completed	(Specify only highest grade		(Give	kind of work done DO NOT use retire	during most of w	rorking	16b. Kind of Business	rindustry
7	with ene.	m C	Elementary/Secondary (0-12)	College (1-4or 5+)	Nurse	20 1101 200 101110	w)		T. C. A	
ם מ	filed Hygie other		17. Father's Name (First, Middle, Last)		Mulse		18. Mother's N	ame (First, Middle, N	J.S. Army Naiden Sumame)	
an	Mental Merked o	o Be	William Alexander	D 1-					,	
<u></u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is marked other then "naturet", or iteme 23a or 28a-1 show aumatic event, it a Madical Export or mail to notified at	2	William Alexandria  19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street	Nellie ]	Bender Bural Boute Number	City or Town, State,	Zin Code)
Maryland 21215-0036	is 1 and 2 should by Health and Men item 27 is marke other traumatic		Richard Roelke, nep	•						
	1 and 1 Health tem 27		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of		Date 2	19, Thurn	Town, State
altimore,	Pages nent of I int: if its ury or o		1X Burial 2 □ Cremation 3 □R	emoval from State	emetery, crer	natory or other pla				
	ortan ortan njury		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		. Ulive	t Cemete	ry 1/18	3/2007 F1	rederick,	Maryland
B	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Pulleral Service Literase		2000	. Name and Addre	Ke	eney and	Basford Fu	neral Home
			23a. Part . Enter the disease, or complic	MU(	1999 IC	6 East C	hurch St	reet, Fre	derick, MI	21701 Approximate
8760,	Physician and //Medical Examiner (the prinal-transit the prinal-transi	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a))).	uence of):					Onset and Death
9	rtifica ng ph as th	Med	ic ccimi e							
P.O. Box	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	Sc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	I death 3	Ectopic pregnancy Other (specify)	/		23d. Date of del Month	ivery Day Year
J.	s that ned b		Part II. Other significant conditions con	tributing to death but not res	ulting in the u	ndertying cause giv	ren in Part I.	23e. Did tob	acco use contribute to	the cause of death?
S	uires n sign	d D	Coronary Artery D	isease				1 ☐ Ye	s 2∭No 3∏Pr	obabły 4 🗆 Unknown
ဂ္ဂ ပ	w requir been s should	Completed by	Pulmonary Fibrosi	_				24a. Was an	24h Were au	stoney findings available
e T	The lav	E C	Fullionary Fibrosi	8				autopsy	prior to death?	topsy findings available completion of cause of
ā		Ö	25. Was case referred to medical						X No 1 ☐ Yes	2 □ No
5	Attending Physician: If death. ector: After this certific by the funeral director.	o Be	examiner?	ospital:	-	Oth		eath Check only one		11-2-7
ō	Phy rald	$\vdash$	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of			Home 5 Resider	nce 6 Other (Spec	cify)
0	ding I h. After funer	tior	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2∐No		,,	
<u>s</u>	r Attend er death rector: /	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str			28f. Location (Str.	eet and Number or Ru	ural Route Number
Division of Vital Records,	i or A after Dire	erti	4 Homicide determined	building, etc. (Special	(y)	,,		City or Town,	State)	Tall to a little t
	Hospita 4 hours Funeral	edicai C	29a. Certifier 1 X Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death	n occurred at the tir restigation, in my o	ne, date and place epinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Monti	h, Day, Year)
)			1/2	MATT		D0060	417	To	nuary 14,	2007
	2		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Tvoe		71/	Ja	muary 14,	2007
	3		Hemen Shah, 65C The	omas Johnson	Drive	Frederic	ale Massa	land 2170	12	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	1 rener I	rialy	ranu ZI/(	14	
	Registr		JAN 2 4 2007	Blocker S.	SOSA					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month Day **Physician** narles 2 January 14, 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Fort Washington Hospital Fort Washington Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (Stete or Foreign Country) 1**⋈**M 2□ F Months Days Yrs. Director 577-66-9994 Jan. 4, 1950 Wash., DC Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "neturel", or Items 23s or 28e-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits in than "neturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Charles Waldorf Md. Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2748 Sun Valley Drive 20603 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2□No
If Yes, Give 1969
Year or Dates: 1969 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1969 1971 Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛛 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk US Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Butler 2 Mary Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2748 Sun Valley Drive
Waldorf, Md. 20503

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other treu Barbara Butler/wife 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 1/22/07 Clinton, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Mediate Cause (Final **Physician** oxle disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Pol in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Cther (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed certificate 2 Z No 1 Yes 2 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Certification: To 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural after death. 1 Yes 2 No 2 Accident the 6 ☐ Could not be 3 Surcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Homicide To the Hospital 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) D0054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIV 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year by 07 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 M 2 X F Yrs Director 78 577-34-0630 MARCH 9, 1928 MARYLAND Usual Residence of Decedent death with the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notifled at Director 1 ☐ Yes 2X No MARYLAND WASHINGTON SHARPSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18033 BURNSIDE BRIDGE ROAD 21782 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify. 3 X Widowed 4 ☐ Divorced "natural", WHITE Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien. Important: if item 27 is marked other tha any injury or other traumatic and 4 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SEWELL CREEL MARY (UNKNOWN) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD F. BODDIE/SON 6520 BOWIE DRIVE, SPRINGFIELD, VIRGINIA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 D Other (Specify) REST HAVEN CEMETERY 01/15/2007 HAGERSTOWN, MARYLAND 21. Sign sure of F arral Service 22. Name and Address of Facility 7606 Old national Pike BAST FUNERALHOME Paul M. Dean ŧ Boonsboro, Maryland 23a. Part1. Enter the disease, arcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SUDDU N /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. physician Physician/Medical the as attending p IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknow signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate | performed 1 ☐ Yes 2 ☐ No or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes Yes 2 No 1⁴ Inpatient 2 ER/Outpatient 3 DOA ျ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Division Certification: 1 Natural 5 Pending Injury 2 Accident 3 Suicide investigation m 5 07 1 Yes 58 7411 6 Could not be determined 28e f lace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide CUrb Romnewood Me dicticenta 47 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0011266 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 580

JH-10

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LOIS ANN BOLKA 01 04 2007 1701 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) JAN • 30, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2**X** F 218-16-4439 82 Director MARYLAND Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits a or 28a-f sh MD 1 ☐ Yes XXNo Director ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 1 ury or other traumatic event, the Medical Examiner must be nury or other traumatic event, the Medical Examiner must be no 901 SETON DRIVE 21502 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3X Widowed 4 □ Divorced Year or Dates: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 FOOD SERVICE DIETICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSHUA P. JOHNSON MILDRED F. PAGE မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHAYANNE JACOBS/GRANDDAUGHTER P.O. BOX 260, FORT ASHBY, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 'Department of H Important: If tte any injury or ot once. 1 Buria! 2 □ Cremation 3 □ Removal from State DAVIS MEMORIAL CEM. 01/08/2007 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Services UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heunt Failure **Physician** disease or condition resulting in death) 2 years /Medical Due to (or as a consequence of) Examiner stroke Sequentially list conditions, if any mading London cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ advanced Dementica 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 s 1□ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 20 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1: Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide thin 24 hours at the Funeral D mpletely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) within 2 To the I To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) · wonsockshir MD 00055325

State Registrar

48 Turn WONSOCK SHIN 31. Date filed (Month, Day, M 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terrace 1022 EL

Frostburg MD 2153

January 05, 2007

			1 - State of Maryland / Department of Health and Certificate of Death		2001	01757
	-		Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death
	Physici /Medic		WILLIAM RAY BERKLEY	JANUAI	Day Yei	07 13:00PM <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De		4c. County of D	
			913 NATIONAL HWY LOT G LAVALE		ALLEGAN	Y
	Funeral			lin. (Month, Da	y, Year)	Birthplace (State or Foreign Country)
Н,	Director		Usual Residence of Decedent	8-8-19	25 <u>M</u> a	ryland
	death with the Maryland ms 23a or 28e-f show		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
:	e Ma	ctol	MD ALLEGANY LAVALE			1 □ Yes 2X No
:	or 24	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
	s 23s	Funeral Director	913 NATIONAL HWY LOT G 21502		UNITED ST	
	ter de	un-	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  12 Married  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	- 14. Hace - A Black, W	merican Indian, /hite, etc.
	urs at	by	1 □ Never Married 2 □ Married  1 ☑ Yes 2 □ No  If Yes, Give Unknown  1 □ Yes 2☑XNo Specify:		Specify: W	HITE
ה ה	72 ho	ompieted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of vice kind of work done during most of vice kind of work done during most of vice kind of work done during most of vice kind of work done during most of vice kind of work done during most of vice kind of work done during most of vice kind of work done during most of vice kind of vice kind of work done during most of vice kind of vice k	working	16b. Kind of Busine	ss/Industry
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and	d be t antal h	o Be		Name <i>(First, Middle,</i> ACKERMAN	•	
2	should nd Me mark matin	Ĕ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or			e Zio Code)
<u> </u>	nd 2 stith ar		GORDON CARPENTER/ STEPSON 102 SAND PIPER RIDGE			
บ้	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Interportment if them 27 is marked other than "natural, or items 23a or 28e-f show any injury or other treumatic event, it at Marileal Exat is at mast be recitled at Once.	-	20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)	Date	20c. Location - City	or Town, State
altimor	Page nent o int: if		1 Burial 2 Tomation 3 Removal from State 1 Donation 5 Other (Specify)  CUMBERLAND CREMATORY 1/1	1/07	CUMBERLAND	MD
20	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		50 W. MAIN	СТ
<u> </u>	8355		Hen 30 Sowers mousty SOWERS FUNERAL HA	OME, P.A.	FROSTBURG	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on lach line.	rae or respiratory a	rest,	Approximate Interval Between
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1	/Medical Examiner		resulting in death)  Due to (or as a consequence 1):			01-21-30-0-1
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Š	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of	*
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<u> </u>	or Att ter de irset n by t	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox		Rural Route Number,
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:	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edicai	29a. Certifier  (Check only one)  Check only one)  Check only one)  Check only one)  (Check only one)	ace, and due to the courred at the time,	cause(s) and manner date and place, and c	as stated. fue to the cause(s)
:	o the o the omple	Me	29b. Signature and title of contriber / 29c. License number		29d. Date signed (Mo	onth, Day, Year)
1	10		1/1/1/12/1- A ON MAN DO 21	ا رم	Con set 1	11 2000
			30. Name and address of person who complete cause of death (Item 23a) (Type, Print)		MUARY	11,0001
	nds		GARY L. WAGONER,, M.D., 925 BISHOP WALSH DRIVE, CUM	BERLAND	MD 21502	
	Sta		31. Date filed (Month, Day, Year)  32. Registrats Signature			
	Registr	ar	JAN 1 2 2007 > Regge & Sparke			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CARL 04 BENNETT 01 2007 ALLEN 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) 27 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F Maryland 79 216-22-6289 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he northland as 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 13501 McMullen Highway United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1X Yes 2 If Yes, Give Year or Dates: 2 □ NS Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Driver Local Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leona Belle (Kennard) Carl Calhoun Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn J. Bennett / wife 13501 McMullen HWY, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/8/07 Gap Veterans Flintstone, MD Adams Family Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 166405 Physician iVer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execut.) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760, physiciar Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Year 5 Other (specify) signed by the a d be detached f Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy pertorm within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 2 □ No 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) Medi and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00060478 510 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MLS Afaq Ahmad, M.D. 625 Kent Ave., Cumberland, MD 21502 31. Date filed (Month, Day, Year) ₽egistrar's Signature JAN 0 5 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Ruth Elizabeth Bowersox January 6, 2007 6:25 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 □ M 2 3 F Days 214-01-0454 91 Yrs Director Mar 13, 1915 Maryland Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location in then "neturel", or iteme 23s or 28e-f show the Medical Examiner must be notified at 10d. fnside City Limits Westminster Maryland Carroll 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 340 Margaret Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes, Give þ Specify: WHITE 3 ₩ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress permit. Peges 1 and 2 should be filed v Department of Health and Mental Hygien Important: If item 27 ie marked other th eny injury or other traumatic event, this once. 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) "Unknown" Yingling Sadie Strevig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 West 3rd Street, Bethany Beach, DE 19930 Paul E. Bowersox, Jr., son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) St. Mary's Cemetery 01/12/2007 Silver Run, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01191 Myers-Durboraw Funeral Home tay 91 Willis Street, voice Westminster, MD 21157 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death diate Cause (Final Physician SHD disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner signed by the attending physicien and it be detached for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? ۵ as been si 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed rector, page 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA this 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 28c. fnjury at Work? After or Attending 1 Natural is efter dea. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SV DUO61755 W 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Dr. Hemalatha Naganna, 700A Poole Road, Westminster, MD 21157 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State JAN 09 2007 Registrar

To the twithin 2 complete

State Registrar

DHMH 17 Rev 1/2001

ARROWWOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

266

00058410

CT. SALISBURY NO 2180

		4	State of Maryland / Department / Department State of Maryland / Department / Depar	ent of Health and ate of Death		iene 007	01761
			Decedent's Name (First, Middle, Last)		2. Date of Dea	th	3. Time of Death
	Physici		Elizabeth Mary Browne		January	7 15, 2007	0658 A M
1	/Medio Examin			ity, Town, or Location of Dea		4c. County of Dea	
	Examili	eı		ising Sun		Cecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un	der 1 Year   If Under 24 Hr		9. Bir	thplace (Stete or Foreign
	Director		222-03-2412 1 M 2 DF 87 Yrs. Mont	ns Days Hours Mir	OCT 15,	Year	elaware
			Usual Residence of Decedent		, , , ,		
	ylan		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ma-	ģ	Maryland Cecil Rising Sun				1 ☐ Yes 2 📉 No
	h the	Director		Zip Code	1	0g. Citizen of What Co	•
	filed within 72 hours after death with the Maryland Hybiene. Ither than "natural", or Iteme 23a or 28a-f ehow Inter tha Medical Examinational be notified at	a	1881 Telegraph Road	21911		United St	ates
	dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De Armed Forces?	cedent of Hispanic Origin? (	(Specify Yes or No-	14. Race - Ame Black, Whit	
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را ا	72 h natu	etec	15. Decedent's Education 16a. Decedent's U (Specify only highest grade completed) (Give kind of	work done during most of w	rorking	16b. Kind of Business	/Industry
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밀	d off	Be	17. Father's Name (First, Middle, Last)		ame (First, Middle, i		
$\frac{8}{2}$	Men Men arke	၉	John Thomas Pawley		a Broomal		
Maryland	2 sh and le m	V. Y		ess (Street and Number or I			
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9	of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	or other place) Jan	nuary 19,	20c. Location - City or	Town, State
Ē	Pag ment ant: uny c		4 □Donation 5 □Other (Specify) Silverbrook	Cemetery 200	)7	Wilmington	. Delaware
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.		21. Signal re of Funeral Service Licensee 22. Name Hicks	and Address of Facility Home for Fur	nerals. P.	Α.	
_	90 E # 9	8 9	103 W	<ul> <li>Stockton St</li> </ul>	reet, Elk	ton, Maryl	and 21921
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the r shock, or heart failure. List only one cause on each line.	node of dying, such as cardi	ac or respiratory arr	est,	Approximate Interval Between
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×	ding	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
8	eth c	lan		c pregnancy		23d. Date of de Month	lwery Day Year
o	he d	Physician/M	1 Yes 2 No 9 Unknown	(specily)			
Vital Records, P.O. Box	The law requires that the deeth certificate has been signed by the ettending fagge 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.	23e. Did to	pacco use contribute to	the cause of death?
ds,	sign d be	d by	HMVer tensoran -		1 🗆 Ye	as 2□No 3□Pi	robably 4 Allakhown
ò	w requir been si should i	Completed		26 ( - 2	24- 146		
ĕ	sician: The law s certificete has b lirector, page 2 s	m Id	Cornary Hoteman	Kisein	24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
<u>~</u>	r. Th						2 □ No
<b>\frac{1}{5}</b>	icertif certif recto	Be	25. Was case referred to medical examiner?  Hospital:	Other	eath (Check only on		
ŏ	Phys this ral di	٠ <u>۲</u>	1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at		ence 6 Other (Spe	cify)
L <sub>O</sub>	Attending Physician: Ir death. Sctor: After this certifice by the funeral director. I	io	t ☑Natural 5 ☐ Pending (Month, Day Year) Injury	Work? 1 ☐ Yes 2 ☐ No	25d. Describe no	ow injury occurred	
S	f or Attend after death Director: /	ca	3 Suicide 6 Could not be		28f Location /St	reet and Number or Ri	ural Poute Number
Division of	for A after Direct In by	Certification:	4 Homicide determined 25e. Place of injury - At nome, farm, street, fact building, etc. (Specify)	tory, once	City or Town		star robto repribat,
	spite		29a. Certifier 1 artifying Physician: To the hest of my knowledge death occur	red at the time, date and place	ca, and dua to the o	se rennant transport	r etatod
	To the Hospitel or Attending Physician: The within 24 burs after death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Examiner: On the basis of examination and/or investigal and manner stated.	ion, in my opinion, death oc	curred at the time, d	ate and place, and due	to the cause(s)
	To the Hospitel within 24 hours a To the Funerel Completely filled	ž	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mont	*******
			Augestildellettel-	2223	30/ 2	SAN 161	th 2007
	76		30. N me and address of person who completed cause of death (Item 23a) (Type, Print)	201 1	1.0	211-4	20.000
_			JAYANTILAL KKATELMI) 13	35ingerly	7 ITVE, 2	1Kten /	リノノノノ
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	ar	JAN 2 3 2007 July Signature & Special				

		•	For State Registrar	State of Maryland		artment of H		and Mer		iene	7 017	163
	(g)		1. Decedent's Name (First, Middle, Last	)				2.	Date of Deat Month		3. Time of	Death
	Physicia		Rev.	John P. Conno	11y,	0.S.F.S.		J	anuary			A <sup>M</sup>
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location o	of Death	-	4c. County of I	Death	
			Annecy Hall			Childs	3			Ceci.	1	
E	Funeral Director		5. Social Security Number 6. Se 221-18-6628	7. Age (In yrs. Is	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, CT 7.	Year)	Birthplace (State of Country)  Ireland	or Foreign
	P _		Usual Residence of Decedent	10- 03	*						10d. Inside C	Sh. Limita
	anylar show	-	10a. State 10b. County		, Town or Lo	ocation						2 ☑ No
	88-1	Director	Maryland Cecil	Cł	nilds	1			·	. 022 (110		- X
	vith tr	Dir	10e. Street and Number	•		10f. Zip Code			'	0g. Citizen of Wha		
	s 23s	rai	1120 Blue Ball Ro	0ad 12. Was Decedent Ever in U.S	6 12	21916 Was Decedent of H		ain? (Specifi	Vas or No-		States American Indian,	
9	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show simplify or other treumatic event, I're Madical Est niner coust be notified at ODGE.	Funeral	11. Marital Status 1   ↑ Never Married 2   ↑ Married	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give		vvas Decedent of h If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	an, Mexican  Specify:	i, Puerto Ric	an, etc.)		White, etc.	
8	urel',	d by	3 Widowed 4 Divorced	Year or Dates:							White	
5	72 h	Completed	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occup kind of work done	during most	t of working		16b. Kind of Busin	iess/Industry	
2	hen hen	m Id	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	<b>a</b> )			Dolici		
7	lled v lygie ther t		17. Father's Name (First, Middle, Last)	5+	rr.	iest	18 Mothe	ar's Name (F	irst Middle	Religi Maiden Sumame)	-011	_
Maryland 21215-0036	ntal hed of	Be		77					Toman	maiddin damame,		
Š	d Me d Me mark matic	2	Thomas A. Connol1  19a. Informant's Name/Relationship (7)	-	19h Maili	ng Address (Street				r City or Town Sta	ate Zin Code)	
N	d 2 st		Oblates of St. Fran	΄ ΄		Kentmere						306
<u>စ</u> ်	1 end Healt em 2		20a. Method of Disposition			osition (Name of matory or other place		Date		20c. Location - Cit		300
کّ	Pages nent of I ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 ☐	riemoval from State			1 -	Januar	y			
Baltimore,	rtmer rtant		4 □Donation 5 □ Other (Specify  21. Signaturg of Funeral Service Ucens			emetery		22, 20		Childs, I		
Ba	Depa Impo eny i		husten Hees	(susman)	H 1	Name and Addre icks Home 03 W. Sto	for	Funer Stre	als, P et, El	.A. kton, Mai		
			23a. Part . Enter the disease, or composhock, or heart failure. List only of	plications that caused the death one cause on each line.	n. Do not en	ter the mode of dyir	ng, such as	cardiac or re	espiratory arr	rest,	Approxima Intervat Be	etween
	Physician		Immediate Cause (Final disease or condition	Lun	a	Can	en				Onset and	Death
	/Medical		resulting in death)	Due to (or as a consequ	uer ce of):							
	Examiner		Sequentially list conditions.	b	Į.							
4	D #	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to for as a cons	ience of:							
ير	and trans	ram	Cause (Disease or injury that initiated events resulting in death) Last	C.	.cmaa af).						_	
,092	ate be executed hysician and the burial-transit	E E	rodaning in doubly succ	Due to (or as a consequ	sence oi):						14	
	cate t	dical		d								
89 x	death certifical e ettending phy d for use as th	by Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	nov					204 D.	-4 d=0	
Box	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy	у			23d. Date of Month		Year
<u>o</u> .	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of de 9 □ Unknown	eath St	☐ Other <i>(specify)</i> _						
Δ.	that the death the by the etter detached for i	F	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the u	inderlying cause giv	en in Part I.		23e. Did to	bacco use contribu	ute to the cause of	death?
ds,	8 5 8					, ,			12Y	es 2 No 3	Probably 4	]Unknown
Ö	w require been sig should b	ete							24a. Was a	24h Wa	en autonou findinou	o avadable
Vital Record	has l	Completed							autop:	sy prio	or to completion of ath?	cause of
E E											Yes 2 No	
<del>=</del>	ysician: is certific director.	Be	25. Was case referred to medical examiner?	Hospital:		Ott	205		Check only or			
o	W 75	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2 2	ER/Outpatie 28b. Time of	III 3L DOX	4 🗀 140			ence 6 Other ow injury occurred		
2	or Steel	ē	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk? ]Yes 2 🔲 l			on injury occurred		
Si	Attending r death. ector; Alter by the fune	ica	3 Suicide 6 Could not be		ome farm st				Location (S	treet and Number	or Rural Route Nur	mber,
Division	lor A efter Direct	ertification:	4 Homicide determined	building, etc. (Specif)		root, radiory, office			City or Tow			
	To the Hospital or Attendi within 24 hours after death To the Funeral Director; A completely filled in by the fi	dicai C	(Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina	wledge, dea tion and/or in	th occurred at the ti	me, date an opinion, dea	nd place, and ath occurred	d due to the d at the time, d	cause(s) and mann date and place, and	er as stated. d due to the cause	(s)
	To the l within 2. To the complet	Med	29b. Signakare and title of certifier	and manner stated.		29c. Licens	se number			29d. Date signed (i	Month, Dav. Year)	
1	2 × 00		200. Signature drive title of certifier		m			1111		1/10	107	
7	-		Colon o				56	44	7	1/18	101	
	15		30. Name and address of person who				7	202	D11 ·	M 1	1 01001	
ij.			Gloria Simonson, N	1. D. III West	High	Street, S	ouite	302,	EIKton	, Marylai	nd 21921	
	Regist	ate rar	31. Date filed (Month, Bay, Year) 2007	32. Registrar's Signa	Agram	Car.						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** MILLARD ELROY CRUM JR /Medical JANUARY 19 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Jun 24, If Under 24 Hrs. . Age (In yrs. last birthday If Under 1 Year Months Days 219-36-4953 9. Birthplace (State or Foreign Funeral Hours 1 X M 2 □ F 73 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at Maryland Frederick Walkersville 1 ☐ Yes 2 📉 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 9619 Stauffer Road 21793 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 No White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farming Agriculture 12 Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Millard Elroy Crum Sr Clara Eunice ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Godsey Crum, Wife 9619 Stauffer Road, Walkersville, Maryland 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Olivet Cemetery Jan 24, 2007 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signatus of Funeral Service 22. Name and Address of Eacility Ford P.A. Funeral Home M00706 106 East Church St, Frederick, Maryland 21701 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Intracranial Hermorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) **Mpatient** 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

burial-tran Division or Vital Records, P.O. Box 68760, the as use Į, signed by the a d be detached for tate has been si page 2 should b within 24 hours after death.

To the Funeral Director: After this certificate or Attending Physician: the 1 filled in by the Hospital

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

show

State Registrar

Medical

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eigh Williams

BW9270290

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Memorial Hospital

1/21/0

Frederick 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mostly Pay Year)

22 Registrar's Signature

			1 - For State Registrar	Stat	e of Ma	ryland / Dep <i>Ce</i>	artmen e <i>rtificat</i>	t of H	lealth a Death	and Me		iene	2007	0 1	766
	D		1. Decedent's Name (First, Middle	e, Last)							2. Date of Deat Month		Vasa		e of Death
п	Physici /Medio		Lawrence :	Lee Cla	ark						Januar	y 8	, 200	7 12	2:18 Mg
	Examir	er	4a. Facility Name (If not institution	n, give street an	nd number)		4b. City,	Town, or	r Location of	of Death		4c. C	County of Dea	ath	
			5314 Wendy						sbur				arrol		
П	Funeral		5. Social Security Number	6. Sex <b>XX</b> M 2□	76	(In yrs. last birthda) A Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day,	Year)	- C	ountry)	ite or Foreign
	Director		494-30-5960 Usual Residence of Decedent		8	4 115.				1 1	Mar 16	, 1	922 j	Kansa	S
	land ow		10a. State 10b. County			10c. City, Town or	ocation							10d. Inside	e City Limits
	Mary	ō	MD Carı	coll		Elder	cehur	~						1 🗆 Y	Yes 2X No
	1 the	Director	10e. Street and Number				10f. Zip				10	Og. Citize	en of What C	ountry?	
	death with the Maryland me 23a or 28a-f show rmatte collified at		5314 Wendy B	5.5				2178	Q /I			USZ	7.		
	deat	Funeral	11. Marital Status	12. Was	Decedent E	ver in U.S. 13				igin? (Spec	ify Yes or No- ican, etc.)		4. Race - Am		١,
و	or its	Ē	1 Never Married 2 Mar	ried 1. Kill	Yes 2 ☐ No es, Give	1942	1 Yes		Specify:		ecan, etc.)		Black, Whi	ite, etc.	
2	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or flema 23a or 28a-f show event, tra Medical Exantian must be cutified at	d by	3 Widowed 4 Divorced	Year	r or Dates:	1952	10165	2120410	эрвспу.				Specify:	White	
2	72 t	Completed	15. Deceden (Specify only highe	nt's Education st grade comple	eted)	(Giv	edent's Usua e kind of wor	rk done d	during mos	st of working	g		d of Business	,	-
2	withir	g E	Elementary/Secondary (0-12)	Colte	ege (1-4or 5+	) life.	DO NOT us	ie retired	1)			Bet	thleh	em St	eer
N	be filed vital Hygie of other terms		12 17. Father's Name (First, Middle,	( ast)		Mech	nanica	al			(First, Middle, N	hidan S	Sumame)		
ä		Be	Joseph Clar	•							Veiss	aideri 3	ourname)		
Maryland 21215-0036	should be ind Mental marked o umatic eve	ဥ	19a. Informant's Name/Relations		r)	19h Mai	ling Address	(Street			Route Number,	City or	Tour State	Zin Co do l	
<u>8</u>	is 1 and 2 should of Health and Mer item 27 Is marks other traumatic			THE (TYPE), THE								•			
စ်	Heal Heal tem 2	3	Rosina Clark 20a. Method of Disposition		Wi:	Fe 5314 20b. Place of Disp cemetery, cri	osition (Nan	dy E	ka.	EIGE	ersbur		MD Z ation - City or	1784 r Town, State	
ē	Pages nent of int: If it iry or o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		from State	I .				. /			•		
Baltimore,	permit. Pages Department of Important: If it any Injury or once.	1	21. Signature of Funeral Service			Lakevie	22. Name an			h.			rsbur		
ñ	Per Oper of the per oper of the per oper of the per oper oper oper oper oper oper oper	l J	D 1/6	11						Prit	ts Fu				-
			23a. Part1. Enter the disease, of	complications t	that caused t	he death. Do not e	112 Wa	ashi e of dyin	ingto g, such as	on Ro	l. West respiratory arre	tmir st.	nster	MD Approxir	
	Pnysician	, ,	Immediate Cause (Final	only one cause	on each line									Onset a	Between nd Death .
	/Medical		disease or condition resulting in death)	d	1 VOCAL	consequence of):	NFAR	con						10 m	nutes
	Examiner					20.1304201100 017.									
		Je.	Sequentially list conditions, if any, leading to immediate	Du Du	ue to (or as a	consequence of):		-							
	cuted nd ransil	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
Ć	en ar en ar irial-t		resulting in death) Last	Du	ue to (or as a	consequence of):									
8/60	death certificate be executed e attending physicien and of for use as the burial-transit	dlcal		d											
٥	ing pl	Med	IF FEMALE:	T				_							
X P P	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes 1 □ L	s, outcome of Live birth 2		□Ectopic pr	egnancy				23	d. Date of de	•	
5		Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Pregnant at ti Unknown	me of death 5	Other (spe	ecify)					Month	Day	Year
7.	hat the	F.	Part II. Other significant condition	one contribution	to dooth hut	not specified in the			- i- D. H		OO- Didash	1			1.1.4.0
Š,	requires that the der een signed by the a hould be detached f	٥	rait ii. Other significant condition	Ans contributing	io deam but	not resulting in the	ungeriying ca	iuse give	en in Parti.	•		accouse s 2 🗗	e contribute to		
ecord	req Bou	ompleted									1 L Ye	2 [9	HNO 3 P	robabiy 4	Unknown
စ္	S 53 B	du									24a. Was an autopsy		24b. Were at prior to	utopsy findin completion o	gs available of cause of
<u>.</u>	Page 1	S									perform 1 ☐ Yes 2		death? 1 ☐ Yes		
VITAI H	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?					1			Check only one				
5	this al die	2	1 Yes 2 No			2 ER/Outpatie		A Othe	er: 4 🗆 Nui		5 Aesider			ecify)	
	ding Phys th. After this funeral dir	o o	27. Manner of Death 1 ☑Natural 5 ☐ Pendin		Date of Injury ( <i>Month, D</i> ay	Year) 28b. Time Injury		Bc. Injury Work			d. Describe how	v injury i	occurred		
<u>s</u>	ttend death stor: the	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be	Diana at Inius		М		Yes 2⊡1						
UNISION	al or Attending F s after death. I Director: After d in by the funera	ertification:	4  Homicide determ	ined 286. F	building, etc.	y - At home, farm, s (Specify)	treet, factory	, office		28	f. Location (Str. City or Town,	State)	Number or Ri	ural Route N	umber,
_	spital or Atten ours after deat seral Director: filled in by the	O	29a. Certifier 1 Certifyin	n Physician: T	o the best of	my knowledge, dea	th occurred r	at the tim	o data as	d place as	al alva to the				
	Hos 24 h Fur etely	edical	(Check only 2 Medical one)	Examiner: On t	the basis of e	xamination and/or i	nvestigation,	in my of	pinion, deat	th occurred	at the time, da	te and p	nd manner as place, and due	s stated. e to the caus	e(s)
	To the Hospital of within 24 hours at To the Funeral Discompletely filled in	Me	29b. Signature and title of certifie		A		29c.	License	number		29	d. Date	signed (Mont	th, Day, Year	r)
	->-0			12	hol	6 MI	>	DZ	w	)		To	nunni	9 7-4.	7
1	JA		30. Name and address of person	who completed	cause of d	th (It = 23a) (Type	, Print)					5 4	uur j	1,200	(
	10		1	nto.	1645	LIBER	4 Ros	el	Eld	lers/n	irg, mi	>	217	184	
	Sta	te	31. Date filed (Month, Day, Year)		Registrar'		7-1-0	-	VIVI	C, ~0//C	11		611		-
	Registr	ar	.IAN 1 0	2007 🗷	Popular	B. On	and s								

			1- For AMEND#23E Per PHY. State of Maryland / Destate Registrar 1/19/07 AACO Health Dept. CMH		ental Hygie	•
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Walter John Chuprun		2. Date of Death Month January	Day Year 3. Time of Death 5 2007 1:00 AM
	Examir		4a. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Home	4b. City, Town, or Location of Death Charlotte Hall		4c. County of Death St. Mary's
	Funeral Director		5. Social Security Number 203-01-8415 6. Sex 1 M 2 F 86 Yr.	Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Y) Oct. 10,	ear) 9. Birthplace (State or Foreign Country) 1920 Pennsylvania
	Maryland e-f show	tor	10a. State 10b. County 10c. City, Town of Maryland Anne Arundel	or Location Annapolis	-	10d. Inside City Limits 1 [] Yes 2 ☑ No
	th with the 23a or 28	al Director	10e. Street and Number 593 Moran Court	10f. Zip Code 21401	10g	Citizen of What Country? U.S.A.
980	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23s or 28e-f show other than "natural", or items 23s or 28e-f show event, the Medical Examinating at	by Funeral	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates: WW II	<ol> <li>Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F</li> <li>Yes 2♥ No Specify:</li> </ol>	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	within 72 ho ene. than "natur he Medical	Completed	(Specify only highest grade completed) (C	ecedent's Usual Occupation Give kind of work done during most of workin te. DO NOT use retired) afety Inspector	ng	b. Kind of Business/Industry altimore City
Maryland 2		To Be Co	17. Father's Name (First, Middle, Last)  John Chuprun	18. Mother's Name		iden Sumame)
	D = 5 = 5			Mailing Address (Street and Number or Rura.  3 Moran Court Annap		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1XX gurial 2 Cremation 3 Removal from State cemetery,	isposition (Name of crematory or other place)  ven Mem. Park 1/9/2  22. Name and Address of Facility Joh  147 Duke of Gloucest	2007 G nn M. Tay	
68760,	Any sician and white burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)  Due to (or as a consequence of)  Due to (or as a consequence of)	thrombosis-	r respiratory arrest	Approximate Interval Between Onset and Death Death Onset and D
P.O. Box 6	law requires that the death certificate as been signed by the attending phy 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Vital Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the Chranic obstructive pulmenary Congestive Near + Failure with di	1		co use contribute to the cause of death?  2 ☑ No SECProbably 4 ☐ Unknown  24b. Were autopsy findings available
al Re	The ate h	Completed	Obstructive sleep aprea	astotic 293 lane	autopsy performe	prior to completion of cause of death?
o	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	ation: To Be	25. Was case referred to medical examiner?  1   Yes 2 No	ne of 28c. Injury at 2		e 6 ⊡Other ( <i>Specify</i> ) injury occurred
Division	el or Atte s after de el Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	i, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	e Hospit 24 hour e Funere	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, one of the basis of examination and/or and manner stated.			
	To th within To th	Me	29b. Signature and title of certifier	29c. License number  D006(882		Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Ty			
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 0 8 Zuur  32. Registrar's Signature			~ marry on 20022

			1 - For State Registrar	State of Marylan			of Health a			ene 2007	01768
15			1. Decedent's Name (First, Middle, La	st)					Date of Death		3. Time of Death
	Physici /Medio		Barbara B. Courb	at					Month anuarv	Day Year 5, 2007	2:40 a M
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Tow	n, or Location of			4c. County of Death	
			Holy Cross Hosp	ital		Silver	Spring	a		Montgor	nerv
*	Funeral		5. Social Security Number 6. S	Gex 7. Age (In yrs.		If Under 1 You Months Da	ear If Under ays Hours		Date of Birth (Month, Day, Y	ear) 9. Birth	pplace (State or Foreign intry)
3	Director		37, 12 03/1		89 Yrs.				ept. 9,	1917 Wash	nington, DC
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	h the Maryland r 28a-f show r notified at	ō	M11								1 ☐ Yes 2 ☑ No
	the I 28a- notif	Director	Maryland Montgo  10e. Street and Number	mery	Ke	nsingto			100	. Citizen of What Cou	
	3a or		3618 Littledale	Road #113			20895			USA	
	ter death with items 23a or iner must be r	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. \	Vas Decedent	of Hispanic Ori Cuban, Mexicar	gin? (Specify	Yes or No-	14. Race - Ameri	ican Indian,
9	after or ite nine		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ▼ No					in, etc.)	Black, White	
21215-0036	y within 72 hours after death with the Maryland piene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	l by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I∐Yes 2√2	No Specify:			Specify:Whit	ce
5-0	72 h 'natu dical	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Deced	lent's Usual Oo	cupation	t of working	16	b. Kind of Business/Ir	ndustry
121	within iene. than "i	шb	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use re	one during mos tired)				
2	e filed value Hygie other t		12 17. Father's Name ( <i>First, Middle, Last</i>		Secr	etary	10 Moth	de Name (Fi	- 4 #4/-1-0 - 4 #-	Governme	ent
and	d be f intal h ed ol	Be	Francis Carroll				To. Motrie			<sup>iden Surname)</sup> te Green	
Maryland	should and Men s marke umatic	2	19a. Informant's Name/Relationship (	Time Print)	10h Mailin	a Address /Str	ract and Number			ity or Town, State, Zi	0-11
Sa	nd 2 sho Ith and 27 Is mo		Kenneth J. Wirsch		1					ryland 208	
<u>a</u>	iges 1 and 2 should be filed it of Health and Mental Hyg If Item 27 Is marked othe or other traumatic event,		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name o	f	Date		c. Location - City or T	
OLL	Pages nent of I ant: If Its ary or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Inemoval Irom State		natory`or other ran's C	<i>place)</i> emetery		12,	•	
altimore,	# 는 분 등		21. Signature of Funeral Service Licer					20			n, Maryland
ñ	Depa Impo any is		A dans	a man						Home Inc.	ng, MD 20901
₩?	₩* 		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	n. Do not ente	er the mode of	dying, such as	cardiac or res	spiratory arrest	, sprin	Approximate
The same	Physician :		Immediate Cause (Final disease or condition	a Pneumonia							Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):						
	Examiner		Seguentially list conditions	b. Acute Myocard	dial In	nfarcti	on				
	D H	iner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):					1	
	and trans	Examine	that initiated events resulting in death) Last	c. Chronic Obst		Pulmo	nary Di	sease		73	
8760,	death certificate be executed e attending physician and d for use as the burial-transit			Due to (or as a consequ	derice oi):						
687	icate phys s the	dical		▲d							
Box (	death certific attending p	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna	ncy					004 D-46-4-1	
ă	death atter	ciar	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregna				23d. Date of deliv Month	Day Year
P.O.	ires that the de signed by the a I be detached i	hysi	9 Unknown	9□Unknown			,				
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death but not resu	ılting in the un	derlying cause	given in Part I.		23e. Did tobac	co use contribute to t	he cause of death?
Ë	w require been sig should b	ba							1 ☐ Yes	2 No 3 □ Prol	bably 4 ∏Unknown
သွ	aw re	Completed							24a. Was an	24b. Were auto	opsy findings available
Ě	The late ha	EO							autopsy performed 1 Yes 2 ☑	d? death?	mpletion of cause of 2□ No
or Vital Records,	stan: ertifica	Be	25. Was case referred to medical examiner?				26. Place		eck only one)	NO TELES	2010
<u> </u>	hysic his ce	입	1 ☐ Yes 2 ⚠ No	Hospital: 1 🔀 Inpatient 2 🔲	ER/Outpatient	3□ DOA	Other: 4 Nu	rsing Home	5 Residence	e 6 Other (Special	fy)
u u	Attending Physician: r death. ector: After this certifice by the funeral director, p		27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. li	njury at Work?	28d.	Describe how i	njury occurred	
Sic	ttend leath stor:	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 N				
É	or A after of Direct in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, rarm, stre	et, factory, offi	ce	28f. L	ocation (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 X Certifying Ph	ysician: To the best of my know	wledge death	Occurred at the	e time date and	d place and a	tue to the cour	a/e) and man	tated
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medical Examone)	niner: On the basis of examinat and manner stated.	tion and/or inv	estigation, in n	ny opinion, dea	th occurred at	the time, date	and place, and due to	o the cause(s)
	ro th Nithin Sompl	§	29b. Signature and title of certifier			29c. Lice	ense number		29d.	Date signed (Month,	Day, Year)
	Q		Kshama	harf M.	n	D	60826			January	
	D	-	30. Name and address of person who			Print)					
_			Kshama Garg, M.				Silver	Spring	, MD 20	910	
	Sta		31. Date filed (Month, Day, Year) JAN 0 9 20	32 Seglstrar's Signat	ture	A.					
	Registra	ar	JAN U J ZU	07 Down L	T. Cold	Well					

Physician /Medical Examine

To the Hospital or Attending within 24 hours after death. To the Funeral Director; After

Division or Vital Records, P.O. Box 68760,

	1 Burial 2 □ Cremation 3 □ Rem	noval from State	cemetery, crematory of	r other place)	Jan. 11		Location - City of	Town, State
	4 ☐Donation 5 ☐ Other (Specify)	S	t. Mary's Ce	metery	2007	Was	hington,	DC
	21. Signature of Funeral Service Licensee		Franc	and Address of Fac	Îlins F	uneral H	ome Inc.	
	xpermy & Co	Stay	500 t	niversit	y Blvd,	W., Sil	ver Spri	ng, MD 2090
	23a. Part1. Inter the disease, or complicat shock, or heart failure. List only one	tions that c is sed the cause on each line.	leath. Do not enter the m	ode of dying, such	as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
ı	Immediate Cause (Final disease or condition resulting in death)	Respirato						- Onsor and Board
		Due to (or as a con						
<u>.</u>	Sequentially list conditions.	Chronic Ob:	structive Pu	lmonary	Disease			
Examiner	if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury	Dae to for as a con	sequence ory.					
сап	that initiated events c	Due to (or as a con	cognopos of):				<u>.</u>	
		Due to (or as a con	sequence or).					
<u>5</u>	d							
Mec	IF FEMALE:							(-)
an/l	23b. Was decedent pregnant 23c.	If yes, outcome pf pre 1□Live birth 2□I	egnancy Fetal death 3 □Ectopio	pregnancy			23d. Date of de	
Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time	of death 5 ☐ Other	(specify)			Month	Day Year
l,	9 🗆 Unknown							
Ş	Part II. Other significant conditions contri	outing to death but not	resulting in the underlying	cause given in Pa	rt I.	23e. Did tobacco	use contribute to	the cause of death?
Completed by Physician/Medical						1 Tyes	2  No 3  P	robably 4 Unknown
lete	f.					24a. Was an	24b. Were a	utopsy findings available
ᄩ						autopsy performed?	death?	topsy findings available completion of cause of
ပိ						1□ Yes 2□X	lo 1 ☐ Yes	2 □ No
Be	25. Was case referred to medical examiner?	spital:			·	Check only one)		
2	T res 2 ANO	1Inpatient	2 XR/Outpatient 3	DOA GIIGI 4	Nursing Home	5 Residence	6 □Other (Spe	cify)
Ë	Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea		28c. Injury at Work?		I. Describe how inj	ury occurred	
äti	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M	1 ☐ Yes 2	□No			
ţ	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - A building, etc. (Sp	At home, farm, street, fact ecify)	ory, office	28f	Location (Street a City or Town, Sta	and Number or R te)	ural Route Number,
Cer					- 6			
dical Certification:			knowledge, death occurr nination and/or investigat					
Ü	one)	and manner stated.		on, army opinion, c		at the time, date a	na piace, and gu	o to the badde(s)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and itle of certifier

31. Date filed (Month

Steven

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grufferman

MD

egistrar's Signature

29c. License number

D 24348

Forest Glen Rd., Si Wer Spring,

29d. Date signed (Month, Day, Year)

01.06.2007

			1 - For State Registrar	State of	Maryia		artment of I <i>rtificate of</i>		Mental Hy	/giene Reg. No.	2007	01770
	Physici	an	1. Decedent's Name (First, Midd	le, Last)					2. Date of De	eath Day	/ Year	3. Time of Death
	/Medi		Alice Juan		lson				Januar			12:29 PM
	Examir	er	4a. Facility Name (If not institution	n, give street and num	ber)		4b. City, Town,	or Location of Dea	ith	4c.	County of Death	1
	- * · · · ·		Manor Care-Be 5. Social Security Number		Ann (In un	n loot birthdou		thesda If Under 24 Hrs	S O Data of Bi		Montgom	
Ы	Funeral Director		220-34-4637	1 M 2 DxF	9 (	s. last birthday)  Yrs.	Months Days	Hours Min		av. Year)	9. Birth Co.	nplace (State or Foreign untry) Indiana
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		Usual Residence of Decedent  10a. State  10b. County		10c. 0	City, Town or Lo	ocation					10d. Inside City Limits
	e Ma Sa-f s	cto	Maryland Mon	tgomery		Takor	na Park					1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cou	untry?
	s 23a	eral	807 Houston A	venue			20912			USZ		
	er de item ner n	Funeral	11. Marital Status	12. Was Deced	ces?	U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puer	Specify Yes or No rto Rican, etc.)	0-	<ol> <li>Race - Amer Black, White</li> </ol>	
36	irs aff	by	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1⊡Yes 2⊡xNo	Specify:			SpecifyWhit	e
21215-0036	2 hou atura cal E	ed	15. Deceder	it's Education		16a. Dece	dent's Usual Occu	pation		16b. Ki	nd of Business/li	
215	hin 7; s. Medi	ple	(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1	4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo d)	orking			,
2	d wit	Completed		3	101 017		Legal Se	cretary			Law	
p	be file tal Hy d oth	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	, Maiden	Surname)	
<u>yla</u>	should be and Mental s marked o umatic eve	O_	Walter Lov					1	a Pauline			
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Maryian at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations Virginia Flory		7h+02	1	ng Address (Street					
e,	1 and Healt em 2	1	20a. Method of Disposition		-		East Wid		Date Date		AZ 85 /	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other trai		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (5				sition (Name of matory or other pla Ltan Crem		Jan. 8,		,	
a	rmit. porta porta y Inju		21. Signature of Funeral Service	Licensee	_	F22	Name and Addre	ess of Facility		l Hom	exandri e Inc	a, Virginia
<u> </u>	9 9 E E 9		ame	5 5 000	Per	150	O IInivar	city Bly	A IN D	247		g. MD 20901
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	complications that can only one cause on each	used the dea	ath. Do not ent	er the mode of dyi	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Multi-O	rgan F	'ailure						Onset and Death
1	/Medical Examiner		resulting in death)		r as a conse							
	- Adminion	-	Sequentially list conditions,	End-Stag		encia						
	ted nsit	nine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to by	as a conse	equence organic						
	al-tra	Examiner	that initiated events resulting in death) Last	c Due to (o	r as a conse	equence of):						
68760,	ificate be executed g physician and as the burial-transit	Sal		C <sub>d</sub>								
9	tificat g phy as the	ledical		- U.								
ŏ		N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome pf preg th 2  Fe		7m-4-=:- ======			2	3d. Date of deliv	very
B	deat e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of		]Ectopic pregnanc ]Other (specify) _	y 			Month	Day Year
P.O. Box	at the by the	Physician/N	9 Unknown									
Ś.	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use		Part II. Other significant conditi Failure To The				nderlying cause giv	en in Part I.				the cause of death?
Records,	w require been sign should b	Completed by		210, 05000	POLOB				10	Yes 2	□ No 3 □ Pro	bably 4 ⊠Unknown
ec Ş	has b	E P			_				24a. Was auto		prior to co	opsy findings available empletion of cause of
		2							perfo 1 Yes	rmed? 2 ☑ No	death?	2 □ No
Vital	siclan: The certificate hir	Be	25. Was case referred to medica examiner?	Hospital:			Ott		ath (Check only o			
ō	Phys r this ral dii	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Ing 28a. Date of		ER/Outpatien		4 Xivursing F	Home 5 ☐ Resident			fy)
DIVISION OF	ding h. : Afte fune	ij	1 Pendir 2 Accident investi	g (Month,	Day Year)	Injury	Wor	k? Yes 2∐No	20d. Describe	now mjury	Occurred	
	Atter r deal ector by the	fica	3 Suicide 6 Could 4 Homicide determ		f injury - At	home, farm, stre	eet, factory, office		28f. Location (	Street and	d Number or Run	al Route Number,
ā	s afte	Certification:	4   Hornicide	building	g, etc. (Spec	eny)			City or Tox			
	To the Hospital or Attending Physician: whith 24 hours after deals.  To the Funeral Director: After this certification the funeral director, and the funeral director director, and the funeral director director director directors.		Check only 2 Medical	ng Physician: To the b Examiner: On the bas	est of my kr	nowledge, death	occurred at the ti	me, date and place	e, and due to the	cause(s)	and manner as s	stated.
	the hin 24	Medical	(ile)	and manne	r stated.							
	N S S S	-	29b. Signature and title of certifie	0.1			29c. Licens	1659			e signed <i>(Month,</i> uary 8,	
•	15	-	20 Name of C	<u> </u>	ad also - 11 - 11	00c) (T	الا			- Cuil		
			30. Name and address of person Raman Tuli,				wn Road,	Gaither	sbura. M	arv1	and	
	Sta	te	31. Date filed (Month, Day, Year)	32 Reg	gistrar's Sigr	nature			3,			
	Registr	ar	P A same	2007		M. Man	1000					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Daniel Cornish, Sr. 03 1358 M Jan 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury

Salisbury

Hours | Min. Peninsula Regional Medical Center Wicomico 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months **№** M 2 | F 217-28-3211 74 Director Jan 22. 1932 MD Usual Residence of Decedent 10c. City, Town or Location 10a, State r 28a-f show notified at 10d. Inside City Limits show 1√Yes 2□No Director MD Wicomico Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be a 28175 Allen Cut-off Rd. 21822 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 7th Salvage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Howard Cornish Helen Cornish 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donzella C. Winder/daughter 8704 Shell Rd., Delmar, MD 21875 20b Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Acres Mem Park 1/8/2007 Salisbury, MD 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Lewis N. Watson Funeral Home ala watson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HROMBO EMBOLIC DISEASE **Physician** /Medical Due to (or as a consequence of) Examiner SEVERE SEPSIS Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed RENAL INSUFFICIENCY tran Due to (or as a consequence of burial-P.O. Box 68760 attending physician Physician/Medical CARCINOMA COLON the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) ed by the a 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 Probably 4 → Onknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA ٩ After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural (Month, Day Year) 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063991 01/04/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5A45bUM VAKADARAJAK 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar JAN 0 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KEVIN WENDELL JANUARY 16,2007 4:55 AMM CRAIG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1109 CLARK AVENUE CHARLES WALDORF If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F 30 Director NOV.13,1976 MARYLAND 219-88-5082 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f shov notified at 1 ☐ Yes 2 XXVo Director MARYLAND CHARLES WALDORF the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 1109 CLARK AVENUE 20602 U.S.A. Funeral iral", or items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: 2 Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural" Completed other than "natur 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SHEET METAL WORKER ADJ METALS 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE F. CRAIG ٩ DELORES ANNETTE FORD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTINA JO PROCTOR-WIFE 1109 CLARK AVENUE, WALDORF, MARYLAND 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot MBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) TRINITY MEMORIAL GDNS. 1-23-07 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M004 RAYMOND FUNÉRAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) chex /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Dire to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760 physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Д. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Ves 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 4:55 A M Hunging 1/16/2007 death. 1 ☐ Yes 2 ☑ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide at 1109 Clark 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 70000, MI 117.2007

Registrar
DHMH 17 Rev 1/2001

State

11655

31. Date filed (Month

JAN 2 3

20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Registrar's Signature

			1 - State Registrar	State of Marylan		artment of F <i>tificate of</i>			gienę Reg. No.	.007	01//3
	Physic		Decedent's Name (First, Middle, L     Charles I	Ezery Cutsail				2. Date of De Januar	v 16.	20Ŏ <del>7</del> °	3. Time of Death 11:25 PM
0	/Medi Examii		4a. Facility Name (If not institution, gi Homewood at Cru	ve street and number)		4b. City, Town, o	r Location of Death		4c. (	County of Death	111111111111111111111111111111111111111
	Funeral Director			Sex 7. Age (In yrs. 79	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Sept.	th	Q Righo	lace (State or Foreign tryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or La	cation					0d. Inside City Limits
	sa-f sh	ctor	Maryland Freder	rick W	oodsbo	ro					1 ☐ Yes 2 X No
	death with the Maryland me 23a or 28a-f show	Funeral Director	10e. Street and Number 11606 Creager	stown Road		10f. Zip Code 21798	3		10g. Citiz	en of What Coun	itry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? TYTYes 2 TNo If Yes, Give Year or Dates:		Was Decedent of H fYes, specify Cuba t□ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: Wh:	
15-0	in 72 h n "natu dedical	oletec	15. Decedent's E (Specify only highest gi	rade completed)	16a. Deced (Give life.	lent's Usual Occup kind of work done OO NOT use retired	eation during most of work d)	king	16b. Kin	d of Business/Inc	dustry
1212	ygiene. ygiene. her the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		y Control H	ngineer			ufactur	ing
land	2 should be find and Mental Hamarked of raumatic ever	To Be	17. Father's Name (First, Middle, Las Harvey S.				18. Mother's Nam Emma	e (First, Middle) Beall	, Maiden S	iumame)	
Maryland 21215-0036	d 2 sho th and h 7 Is me trauma		19a. Informant's Name/Relationship Mrs. Mary L. Cuts	77			and Number or Aur				Code) 21798
ore,	es 1 an of Heali f Item 2 r other		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 [	20b. P	lace of Dispo	sition (Name of	·a)	Date	20c. Loca	ation - City or To	wn, State
Baltimore,	nit. Pagartment ortant: I Injury o		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	fy) Mot	unt Ol:	ivet Ceme	etery Jan				ck, MD
Ba	Depa Impo eny It		▶ Richo E.	MO025!	5 10	Keeney a 06 East C	ind Basfor Church St	rd PA Fo	unera erick	1 Home , MD 21	701
9	Physician /Medical Examiner		23a. Pant1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a consequent	ELL uence of):				rrest,		Approximate Interval Between Onset and Death
\$ 09289	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, teating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				-			
P.O. Box 6	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de	Ideath 3□	Ectopic pregnancy Other (specify)			23	d. Date of deliver Month	ry Day Year
	The law requires that the de ite has been signed by the page 2 should be detached	þ	Part II. Other significant conditions  Pulmorty  EM						obacco use Yes 2□		e cause of death?
Records,	2 5 8	Completed	FIBROSIS,	•			7	24a. Was	an	24b. Were autop	sy findings available
a R	vician: The lav certificate has rector, page 2			•				1 ☐ Yes	rmed? 2 1 No	death?	pletion of cause of
of Vital	hysicia his certi il directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 100	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	3□ DOA Othe	26. Place of Death er: 4 Nursing Ho			Other (Specify)	)
ion	nding P ith. :: After t e funera	ation:	27. Manner of Death  1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work		28d. Describe h			
Division of	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not to determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (5 City or Tox	Street and i	Number or Rural	Route Number,
)	Hospi 24 hour Funer etely till	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the e	cause(s) ar	nd manner as sta lace, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date	signed (Month, E	Day, Year)
)	8		30. Name and address of person who	completed cause of death (Item 65C TH 32 Registrar's Signal 1007	23a) (Type, F	SOHNSON	J DK,	FRED	ERIC	Kind '	21702
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signal	ure dos	de					

Knownto Physican ao: Charles Cutsail

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 20, 2007 **Physician** Year Wyllvs Donahoe 8:30am <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Beverly Living Center of Cumberland Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Feb 7, 1924 **Funeral**  Birthplace (State or Foreign County) **№** M 2□ F Days Hours 216-80-1556 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural" any injury or other treumatic event. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Allegany Cumberland Director 1X Yes 2 □ No 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 512 Winifred Road 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 ☐ No by Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be A. Thomas Donahoe Marie S. (O'Neal) Donahoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rte. 2 Box 431 Williams Rd. Cumberland MD 21502 sister Anna Laing 20a. Method of Disposition
1 ☑ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cometery, crematory or other pi Sunset Memorial Park 20c. Location - City or Town, State 1/23/2007 MD Cumberland 4 □ Donation 5 □ Other (Specify) 21. Signatur of Juneral Service Licentee 22. Nan**Scarbellis Pulital Home**, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) Pnysician hour. /Medical Due to (or as a consequence d) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed use as the burial-transil Division of Vital Records, P.O. Box 68760, resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 □Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) page 2 1□ Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 Xo Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier сопрів(віу 29b. Signature and title of certifie of person who completed cause of death (Item 23a) (Type, Print) HAIMOS 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			For State Registrar	State of M	larylar				ealth a Death	and M		giene Reg. No		7	01775
	Physici /Medio		Decedent's Name (First, Middle, Last     JULES DEITZ								2. Date of De Month JANUARY	2 <b>,</b> 2	2007		3. Time of Death  11:30P
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	Funeral Director			M 2□F 7. A	91	Yrs.	Months		Hours	Min.	Month, Da JUNE 7,	191	9. 5 PI	ENNSY	LVANIA
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9036	ours after dea rs!', or iteme Examinar m	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ₹ If Yes, Give Year or Dates	? ] No	-	Was Dece If Yes, spe 1  Yes		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto I	crfy Yes or No Rican, etc.)	)-	14. Race - A Black, V Specify:		tc.
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	American and Justicien and Jus	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		GE PAR s a consec NT PNE s a consec	UMONIA quence of):	B DISE	ASE							Interval Between Onset and Death
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Division of Vita	Attending Physician: 1 r death. ector; After this certifice by the funeral director, p	ation; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Inpat		ER/Outpatier 28b. Time o Injury		28c. Injury Work	ar: 4 □ Nui	rsing Hon	(Check only one 5 A Resi	dence		Specify)	
Divis	tal or Attences after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inbuilding, e	njury - At h atc. <i>(Speci</i>	nome, farm, str	eet, factor	y, office		2	28f. Location ( City or To			r Rural	Roule Number,
	To the Hospital or Al within 24 hours after of To the Funerel Direc completely filled in by	Medical	29a Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the bes iner: On the basis and manner s	of examina	owledge, deatl ation and/or in	vestigation	n, in my op	oinion, deat	d place, a th occurre	and due to the ed at the time,	date an	d place, and	due to	the cause(s)
•	jp 5∰68		29b. Signature and title of certifier  30. Name and address of person who c	Sort	ti	M.	0	DOC	34726				NUARY 5,		
	Sta	te	JASMINE GATTI, MD  31. Date filed (Month, Day, Year)	8218 WIS	CONSIN	AVE SU	JITE 3		THESDA	, MD	20814				
	Registr		JAN 0 9 20	07		is A	ente								

			1 - For <b>Amend #13</b> Per State Registrar	r State 864 2/05	707 Penice	rtment of F	lealth and I Death	Mental Hy	giene) 0 7 Reg. No.	01776
	Physici		1. Decedent's Name (First, Middle, Las MAR 7 EL(Z	ABETH	DIF	14 URC	0	2. Date of De Month	Day Yeer	3. Time of Death
<i>)</i>	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	1	4c. County of Dea	ath
			HARFOLD METO  5. Social Security Number 6. Se			-,			HARFOR	
	Funeral Director			OM ACIE	76 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da		rthplace (State or Foreign country) ULULGING
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	v. Town or Lo	ocation				10d. Inside City Limits
	r 28a-f ehow	tor	Maryland Harford	l Ha	vre de	Grace				Y□Yes 2□No
	or 288	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	country?
	death with the Maryland ms 23a or 28a-f ehow trivial be notified at		643 North Stokes		0 10	21078	0.1-1.0/0		U.S.A.	
920	72 hours after dea netural', or items	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1  ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba	Ispanic Origin? (S) an, Mexican, Puert Specify:	pecity Yes of No o Rican, etc.)	Black, Wh	
ה ה	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup	ation during most of wor	kina	16b. Kind of Busines:	s/Industry
V	within sne. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retired Maker	d)		Homemaker	,
ם ע	Hygir other	· o	17. Father's Name (First, Middle, Last)		Trome	marcot	18. Mother's Nan	ne (First, Middle	Maiden Sumame)	
yıar	Menta arked atic ev	To B	Benjamin Gerald E				~	Leona Di		
Mar	d 2 sh th and 7 ie m traum		19a. Informant's Name/Relationship (7 Madonna Zellman			•			er, City or Town, State, 2 Grace, Mi	
ē,	s 1 and if Healt itam 2 other		20a. Method of Disposition	20b. F		esition (Name of matory or other place		Date	20c. Location - City o	
E	Pages ment of ant; if i		1 ⊠Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	riemoval irom State	. Erin	Cemetery	1 1/17		Havre de G	
Ball	permit. Departimport eny inj		21. Signature of Funeral Service Licen	0-11					Sruith Funer re de Grace	cal Home, P.A. , MD 21078
-	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conseg	GENI			or respiratory a	rrest,	Approximate Interval Between Onset and Death 2 0A75
	Examiner	ľ	Sequentially list conditions, if any, leading to immediate	b. CONCES  Due to (or as a conseq	TIVE	HEART	FAILL	25		
	uted	mlner		c. /SCHE/70  Due to (or as a conseq						
Ď	be executed sicien and burial-transit	Examin	that initiated events resulting in death) Last							
08/PU	ate he	edical		d CORONA	27 1	RTERT	011645	<i>E</i>		
C. BOX	he death certifics the attending pt ched for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	□Ectopic pregnancy □ Other (specify)	<i>,</i>		23d. Date of de Month	alivery Day Year
بر. ت	law requires that the de as been signed by the a 2 should be detached f	by Ph	Part II. Other significant conditions co		-				obacco use contribute	to the cause of death?
ğ	w require been sig should b	ted	ACUTE RENAL	FAILURE ,	ATRI-	4L FIR	RILLATI	¢~/ 1□·	Yes 2 □No 3 🜠 F	robably 4 Unknown
vitai Records,	The ete h	Completed						24a. Was autoj perfo 1 🗆 Yes	an 24b. Were a prior to death?	utopsy findings available completion of cause of s 2 % No
<u> </u>	Physiclen: r this certific ral director,	o Be	25. Was case reterred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1  Inpatient 2	ER/Outpatier	oth	26. Place of Dea		one) dence 6 □Other (Sp	
0	2 2 2	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				how injury occurred	ecity)
SIO	tendir leath. lor; Af the fur	catlo	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □No			
DIVISION OF	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funera	Certification;	4 Homicide determined	building, etc. (Specif	(y)			City or To		
	• Hoss 24 hor • Fune letely fi	edical	29a. Certifier 1 M Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat ition and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th within To th comp	¥.	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mon	
			V. f. Am	5 MB		102	1338		JANUALY.	14.2007
	12		30. Name and address of person who of ALAN SWEATH	completed cause of death (Item	n 23a) (Type,	Print)	- HOSPIE	AL H	AURF DE	GRACE.
	Sta Registi		31. Date filed (Month, Day, Year)	32 Megistrar's Signa	ature	2000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND of Walfield, PSEVERBERGS63eakf75/107/16/10 Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death  $January 15^{ay}, 200^{Ya}$ 11:30 AMM Carolyn Jean Everly 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1421 Taney Avenue, Apt. 225 Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Feb. 28, 1936 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1 □ M 2(XF Months Days Hours Min. 218-30-7599 70 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Frederick Frederick XXYes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21702 1421 Taney Ave., Apt. 225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X No Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Certified Addiction Councilor Mental Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Semler Max Stine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10914 Rawley Road, New Market, MD 21774 Cynthis S. Young, daughter 20a. Method of Disposition
1 Burial 242 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg Crematory Jan. 16, 2007 Smithsburg, MD 4 Donation 5 Other (Specify) Reeney and Basford PA Funeral Home 21. Signature of Funeral Service License MO0255 106 East Church St., Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manny Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner certificate be executed signed by the attending physician and d be detached for use as the burial-transit Box 68760, P.0. Division of Vital Records, this certificete has been standed at director, page 2 should t : After this certifical funeral director. death. spital or Attendi nours after death. neral Director: A To the Hospital c within 24 hours af To the Funeral D completely filled in

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

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Physician/Medical

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Completed

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Certification: To

cal

29a. Certifier

(Check only one)

29b. Signature and title of certifier.

<u>Funeral</u>

Director

s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygener the Health and Mental Hygener the Theorems 23e or 28e-1 ehow other traumatic event, the Medical Exam an Intellige to 2016.

ò permit. Page Department of Important: If eny injury or once.

**Physician** /Medical

Baltimore, Maryland 21215-0036

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State Registrar

29c. License number D 58391

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) January 15, 2007

turess of person who completed cause of death (Item 23a) (Type, Print)

Sajjed Aziz, M.D., 801 Toll House Ave., C-3, Frederick, MD 21701

31. Date liled (Month, Day, Year)

**ORIGINAL** 

State of Maryland / Department of Health and Mental H												ene	07	01778	}	
	3 34	2	1. Decedent's Name (First, Midd	dle, Last)							2. Date of Death	1		3. Time of Death	1	
	Physic /Medi		Frances Guy	Eggers							Month Januar	,				
	Examir		4a. Facility Name (If not institution	on, give street and	d number)		4b. City,	Town, or	Location of	Death	o direct		nty of Oeath			
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	d within 72 hours atter death with the Maryland liene. r than "natural", or itema 23a or 28a-f show the Medical Exeminat must be troitling at	Funeral	15 Woodmoor		Donadont Ever in	11.6	14/22 D	209		.0.40	77. 24. 24.	144.6	USA			
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36	', or	by F	1 ☐ Never Married 2 ☐ Ma 3X Widowed 4 ☐ Divorce	If Yes	es 215 No , Give or Dates:		1 🗆 Yes	2 <b>₹</b> No	Specify:			Spec	cify:	White		
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7			17. Father's Name (First, Middle				Homemaker						Own Ho	ome		
ıı		Be	James Arthur	/					18. Mother's		First, Middle, M.		,			
χ	should be nd Mental marked o	P								Mar	y Ellen	COLIE				
Maryland 21215-0036	es 1 and 2 should to of Health and Ment litem 27 is marked r other traumatic	0 10	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailii	ng Address	(Street ar	nd Number	or Rural	Route Number,	City or Tow	n, State, Zip	Code)		
	and saith n 27 ser tr		John H. Egger:	s/ Son		4221	Rour	nd Hi	11 Ro	ad,	Silver S	Spring	, MD	20906		
o C	of He		20a. Method of Disposition	0.00		Place of Dispo cemetery, crei	sition (Nar	ne of ther place	)	Da	_		n - City or To	own, State		
Ĕ	Page lent nt: If ry o	1	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		om State Ga	te of H			· I	J	an. 11, 2007 S		c Snri	ng,Maryla	an.	
altimore,	permit. Pages. Department of Inportant: If Ite any injury or of		21. Signature of Funeral Service	Licensee		22	. Name an	nd Address	ol Facility					ng, mary re	2110	
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			23a. Part1. Enter the disease, of	or complications th	nat caused the de	th. Do not ent	er the mod	le ol duino	LLY D.	rdiac or	W., SI	lver :	pring	, MD 2090	JΙ	
			snock, or neart railure. Lis	t only one cause of	on each line.				, such as ca	ardiac or	respiratory arres	ы,	Ì	Approximate Interval Between Onset and Death		
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ó	an a		resulting in death) Last	Due	to (or as a conse	quence of):										
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Вох	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy									23d D	ate of delive	arv		
ă	death atte	cia	in the past 12 months?	in the past 12 months?									Month Day Year			
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٥	res that the de igned by the a be detached f	占	Part II. Other significant conditi	ons contributing t	o death but not re	sulting in the ur	derlying c	alise diver	in Part I		23e Did toba	cco use contribute to the cause of death?				
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ec	2 2 2	ğ									24a. Was an autopsy	24b.	Were auto	psy lindings availab mpletion of cause of	le	
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<u>==</u>	ysician: This certificate	Be (	25. Was case referred to medica examiner?	ti .					26. Place of	f Death (	Check only one					
~	Physician: this certific ral director,	2	1 Yes 2 No	Hospital:	✓ Inpatient 2	☐ ER/Outpatien	t 3 🗆 DO	A Other	4 □ Nursi	ina Home	5 Residen	ce 6 □Ot	her (Specifi	v)		
ō	g Ph er th eral	2	27. Manner ol Death	28a. Da	ate of Injury	28b. Time of		8c. Injury a Work?			d. Describe how			·/		
<u>ō</u>	tending Ph leath. tor: After th the funeral	읉	1 Natural 5 ☐ Pendii 2 ☐ Accident investi	iig .	Month, Day Year)	Injury	м		s 2 No	,						
Division	200>	100	3 ☐ Suicide 6 ☐ Could	nined 286. PR	ace of Injury - At I	nome, larm, stre	et. factory	office	· · · · · · · ·	28	I. Location (Stre	et and Num	iber or Rura	I Route Number.	_	
á	lor A after Direction by	Certification:	4  Homicide determ	bu	uilding, etc. (Spec	ify)	, , , , , ,				City or Town,	State)				
	spita ours seral filler		29a. Certifier Certifyii	ng Physician: To	the best of my kn	owlodes death					4 4 4 4					
	Hos Fun	edicai	(Chack only Z   Madical	ng Physician: To	e basis of examin	ation and/or inv	estigation,	in my opii	, date and p non, death	occurred	at the time, date	se(s) and m and place	anner as st , and due to	ated. the cause(s)		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Mec	29b. Signature and title of certifie	ariu in	nanner stated.			License i								
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	ID 1		_ wus 4	Ruca	M			02	183	5/	$\vee$	ani	LCLIL	, 5 200	70	
	•		30. Name and address of person	who completed c	ause of death (Ite	m 23a) (Type, I	Print)						1	1	t	
					10 790	OI MAPL	EAL	ر ب رسود سيدار	= TA	Kon	1 A PARI	K. MA	RYLIAK	5 200 D 20912	2	
12	Sta		31. Date filed (Month, Day, Year)		Registrar's Sign	ature	Nº -		/			7			_	
18	Registr	ar	JAN 09	ZUU!	Cours L	T. Alon										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year EARL GIBSON FISCHBACH JANUARY 2007 12:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 633 OLD LOVE POINT ROAD **OUEEN ANNE'S** STEVENSVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Director 214-40-2521 64 MARCH 31. 1942 MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MARYLAND QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 633 OLD LOVE POINT ROAD UNITED STATES death 1 21666 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 XYes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1962–1964 1 ☐ Yes 2 X No Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed withir If Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 12 BUILDING INSPECTOR STATE GOVERNMENT permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Importent: if Item 27 is marked othe any lighty or other traumatic event soice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EARL GIBSON FISCHBACH, SR ANNA FLEURY 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN FISCHBACH/SPOUSE 633 OLD LOVE POINT ROAD, CHESTER, MARYLAND 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State JANUARY 8. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 2007 STEVENSVILLE, MARYLAND 21. Signature of Fundal Service Licensee FELLOWS, HELFENBEIN, AND NEWNAM FUNERAL HOME, P.A 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea 23a. Part1. Enter the Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a Box 68760 Physician/Medical use as the attending p IF FEMALE: If yes, outcome of pregnancy
1☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes page 2 autopsy performed? 1 ☐ Yes 28 No death? this certificete Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other 1 Yes 2 No 1 🗌 Inpatient ٩ 4 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident s effer dea. 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medicai one 29b. Signature 29d. Date igned (Mon Name and address of Bers

State Registrar

IAN 9 200

31. Date filed (Month, Day, Year)



		•	1 - For State Registrar	State of Maryland	d / Depa		ealth and M		2007	01780		
	Physici /Medio Examir	al	4a. Facility Name (If not institution, give	epherd F street and number)	east	4b. City, Town, or	Location of Death		: County of Death			
	Funeral Director		Washington Count  5. Social Security Number  486-28-5850  Usual Residence of Decedent		ast birthday) Yrs.	If Under 1 Year Months Days	lagerstowr If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year	Washing 9. Birth 1923 M	gton place (State or Foreign intry) issouri		
e, Maryland 2	within 72 hours after death with the Maryland ene. than "naturel", or lieme 23a or 28a-f show ha Madical Examinar must be motified at	Director	10a. State 10b. County Maryland Wash 10e. Street and Number	nington	, Town or Lo	gerstown	217/0		10d. Inside City Limits 1 ∑Yes 2 ☐ No  10g. Citizen of What Country?			
	nit. Peges 1 end 2 should be filed within 72 hours after death with the Marylar ertment of Heelih and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show injury or other traumatic event, the Madical Examinat must be inclified at injury or other traumatic event, the Madical Examinat must be inclified at a.	Completed by Funeral Director	55 East Washingt  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.s Armed Forces? 1	_		21740 ispanic Origin? (Spe In, Mexican, Puerto f Specify:		USA  14. Race - American Indian, Black, White, etc.  Specify: white			
	ad within 72 ho giene. er than "natur. t, the Medical.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12) 1 2		16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired engine	during most of workir l)	og	16b. Kind of Business/Industry			
	should be filed ind Mental Hygi marked other umatic event, I	To Be (	17. Father's Name (First, Middle, Last) Thomas Eldren Fea  19a. Informant's Name/Relationship (T)		Helen I	(First, Middle, Maide Louise She	p Code)					
	Peges 1 end 2 and 1 and 2 and 1 then		Betty L. Paradisc  20a. Method of Disposition  1X Burial 2 Cremation 3 4 Donation 5 Other (Specify)	o – sister	33 F ace of Dispo		Dr., Hann	nibal, Mis	souri 634	401 Cown State		
Balti	permit. Peges Depertment of Important: If It eny injury or o		21. Signature of Funeral Service Licens	estal	4		ss of Facility ]	Minnich Fu d., Hagers	neral Ho			
/Mo Exa	Physician /Medical Examiner physician and physician and physician and physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are ph	Ilcai Examiner										
P.O. Box 68	The law requires that the death certificat ite hes been signed by the attending phy tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna. 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	very Day Year		
	w requires that been signed b should be dete	ρ	Part II. Other significant conditions co	ontributing to death but not resu	23e. Did tobacco	cco use contribute to the cause of death?						
tal Reco		e Completed	25. Was case referred to medical		26. Place of Death	24a. Was an autopsy performed?  1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No						
	5 2. ₹	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 No Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injun Worl M 1 🗀	fy)					
Divi	o the Hospital or Attending Philibin 24 hours effer death. o the Funerel Director: Affer thempletely filled in by the funeral	ai Certifi	4 Homicide determined	building, etc. (Specify	etedos Jant	Is upperced at the tin	ov data and place a	18f. Location (Street a City or Town, State	e)	etatu i		
<b>)</b>	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	iner: On the basis of examinat and manner stated.	ion and/or in	29c. License	pinion, death occurre	od at the time, date ar	ate signed (Month)	to the cause(s)  Day, Year)		
3 H	1-10+1 Sta Regist		30. Na e and address of person who c	32. Registrar's Signal	100	Print)	t i	had I	1740			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 5, 2007 **Physician** 9:15 p Myrtle Grace Frebertshauser /Medical 4a. Facility Name (If not institution, give street and number) Center Carroll Lutheran Village Healthcare 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 7, 1912 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 94 May 213-50-2444 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Evantrear must be notified at Director Westminster 1 ☐ Yes 2X No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21157 USA 1529 Brehm Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2**%**No Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be then of Health and Mental Bout: If item 27 is marked or Beulah G. Shaffer Francis C. Frebertshauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) brother permit. Pages 1 and 2. Department of Health ar Importent: If item 27 le 5353 Compass Cove Place, Ft. Pierce, FL 34949-8417 Robert W. Frebertshauser, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ St. John's (Leisters) 01/10/2007 Westminster, MD injury 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01191 Myers-Durboraw Funeral Home any. 91 Willis Street, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UMOR **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical the use as t IF FEMALE . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Year 4☐Pregnant at time of death 5 Other (specify) o the detached Š ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 certificate Division of Vital Yes Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only only examiner? Other: 4 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: After Injury at Work? 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide thin 24 hours a 1 🗹 Certifying Physician: To the best ol my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel the within To the 29b. Signatuse and 2 WIL ne and address of person who completed cause of death (Item 23a) (Type, Print) 2 REUS/ER Date filed (Month, Day, Year) **JAN 0 9** 2007 Registrar

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State of Maryland / Department of Health and Mental Hygien  1 - State Registrar  Certificate of Death  Reg. No.										20	2007 01782					
	° Physicia		1. Decedent's Name (First, Middle,	Last)					1	2. Date of Dea Month	th Day	Year	3. Time of Death			
	/Medic		Theresa Loddo				4b. City, Town, o			January		007	11:59 P.M			
	Examin	er	4a. Facility Name (If not institution, Hillhaven Assisted I		1	ity of Death	orge's									
	Funeral		5. Social Security Number	6. Sex 7. A		last birthday)	Adelph	If Under	24 Hrs.	8. Date of Birth		9. Birthp	oface (State or Foreign			
	Director		579-48-3667 1 M 2 N F 76 Yrs. Months Days Hours Min. J								,1930 Pennsylvania					
	and		Usuaf Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ecation			· · · · · · · · · · · · · · · · · · ·		1	10d. Inside City Limits			
	Mary I sh	tor	Maryland Prince	e George's	Ве	ltsvil	le						1 ☐ Yes 2X No			
	or 28s	Jirec	10e. Street and Number	Ctooob			10f. Zip Code	-			Og. Citizen of					
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than Madical Examiner must be notilited at	Funeral Director	13010 Blairmore		Fire in 11	0 40	20705		-:-0 (0							
10	r item	Fune	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Armed Forces' ad 1 ☐ Yes 2	?		Was Decedent of H if Yes, specify Cuba	an, Mexican  Specify:	, Puerto R	ican, etc.)		ace - Americ lack, White,	etc.			
036	ours a	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	If Yes, Give 1 ☐ Yes 2 ☐XN						Spec	Specify: White				
15-0	"natu	etec	15. Decedent' (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most	t of working	g	16b. Kind of I	Business/Ind	dustry			
12	withir iene. r than	Completed	Elementary/Secondary (0.12)	College (1-4or	5+)		Teacher	2)			Educat	ion				
nd	be filed ital Hygir of other event, II	BeC	17. Father's Name (First, Middle, L		1.				,	(First, Middle,	Maiden Suma					
yla	ould by Ment	To	Salvatore		oddo	1		Rose					ocke			
Maryland 21215-0036	id 2 sh Ith and 27 ia n traun		19a. Informant's Name/Relationsh Roland Forbes -h	1 1 2 2			ng Address <i>(Street</i> Blairmon									
re,	is 1 ar		20a. Method of Disposition			lace of Dispo	sition (Name of	ca)	Da	ite	20c. Location	n - City or To	own, State			
imo	Pages ment of I ant: if its ury or o		1 🖾 Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (Sp		Ga	te of	Heaven Ce	emeter	y 1/1	L1/2007	Silve	rSpri	ng,Maryland			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Present in the Marginstit if them 21 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Marginal Examiner must be notified at once.		21. Signature of Funeral Service L	censee	20	Ď	Namland Addre	Borgw	ardt	Funera	1 Home	, PA				
			23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate													
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on each I	ine.	mle	2						Interval Between Onset and Death			
	/Medical	resulting in death)  Due to (or as a consequence of):									SIGRANS					
	Examiner	_	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events c.													
	nsit	Examiner														
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89 x	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy								234 D	late of delive	of delivery			
Box	death e atten d for u	lcian	1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify)								23d. D	Day Year				
P.0	that the death hed by the atter detached for u	hys	9 Unknown													
	90 90	by	Part II. Other significant condition	is contributing to death t	but not res	ulting in the u	nderlying cause giv	en in Part I.			bacco use cor es 2□No		ne cause of death?			
Records,	w requir been si should I	letec								24a. Was a			psy findings available			
Re	0 5 0	Completed	-							autops	ned?	prior to cor death? 1 \( \sum \text{Yes}	mpletion of cause of			
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?					26. Place	of Death (	1 ☐ Yes Check only on		1 105	2 15 10			
of <	8 8	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati		ER/Outpatier		4 - 190		e 5 ☐ Reside			r)			
	ding h. After fune	tion:	27. Manner of Death  1		ury ay Year)	28b. Time of Injury	Wor	yat k? Yes 2⊟1		ld. Describe h	ow injury occu	irred				
Division	Attending or death. ector: After by the funer	Certification:	3 Suicide 6 Could not determine	ot be 28e. Place of In	jury - At ho	me, farm, str	eet, factory, office					nber or Rura	I Route Number,			
۵	Hospital or 24 hours afte Funeral Dir tely filled in	Cert		building, e						City or Town						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fr	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner si	of examina	wledge, death tion and/or in	n occurred at the tirvestigation, in my o	ne, date and pinion, deat	d place, an th occurred	nd due to the ca d at the time, d	ause(s) and m ate and place	nanner as st , and due to	ated. the cause(s)			
	To the I within 2: To the I complet	Med	29b. Signature and title of certifier	and manner si	14100.		29c. Licens	e number		2	9d. Date sign	ed (Month, I	Day, Year)			
)	3		> Rustud	lhour	_		D	52	38		1	18/	07			
	_		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type,	Print)		C 1.7	10 00	- 07 A	110	2010/			
	Sta	te	31. Date filed (Month, Day, Year)	MUVSUU 32 Regist	rar's Signa	ture _	rewood	87.	aut	V HUS	al	wer.	v spring ma			
•	Registr		31. Date filed (Month, Day, Year)	2007 Maria	as the	X Sp	and it									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0vid Bush Frost.Sr. Januari 1900 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town or Location of Death County of Death **Examiner** cial Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) . Birthplace (State or Foreign Country) Funeral Months November Days 1 M 2 □ F Hours 253-26-4277 82 Yrs. Director 12,1924 GA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State ural", or Items 23a or 28a-f show I Examiner must be notifled at 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1702 Temi Drive 20601 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∏Yes 2 □ No If ¥es, Give Year or Dates: 10. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Completed by White 3 ∠Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu, any Injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Walter Frost, II Stella Ivey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Gundling/Daughter 1702 Temi Drive, Waldorf, MD 20601 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 1/18/07 Cheltenham, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22 AREHART ECHOLS FUNERAL HOME, P.A. M00945 Echa St. Mary's Ave. La Plata,MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** Preumono Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 Yes 2 No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 autopsy perform this certificate Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one Hospital: Other: 4 \( \sum \) Nursing Home 200 No 1 Tyes 2 ER/Outpatient 3 DOA 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of D th 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 1 Yes 2 No within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

841

Registrar

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

Vembroo!

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Phillip Michael Franklin A 15 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 17,1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 557-50-8009 69 0klahoma Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 No Director Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1132 Sunnyside Drive 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Lockheed Aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamine E. Franklin Edna Mae Butts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary N. Franklin/Wife 1132 Sunnyside Drive, Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg Crematory 1/19/2007 4 Donation 5 Other (Specify) Smithsburg, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rest Haven Funeral Chapel 21742 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) yes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð nelleli 1 Ves 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy 1□ Yes 2 1 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 36655 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cast 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician JANE BETTY GRIFFITHS 03 2007 /Medical 1315 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1□ M 2□F Yrs. Director 213-24-5072 July 18,1924 West Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d, Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notifled at 1 Yes 2 ☐ No MD Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 N. Liberty St. Apt 201 21502 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: If item 27 Is marked other that any injury or other traumatic event, the ignee. 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Samuel Doyle 2 Olive Rosalee (Fansler) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Shaw daughter 12215 Shadoe Hollow Rd NE, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖔 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park: 1/06/07 Cumberland, MD 21. Signatur of Juneral Service Licer 22. Name and Address of Facility Adams Family Funeral Home, P.A. Kalud 404 Decatur St., Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused e death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of cath one. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MONTHS ANCREATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ DISEASE 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 HO 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0054004 Wy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Khanna

JAN 0 4 2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

1221 E. National Highway, Cumberland, MD

21502

			1 - For State Registrar	State o	of Maryla		artment o			Mental Hy	giene Rog. Né	2007	01	188	
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent's Name (First, Middle, Last)								2. Date of De	ath		3. Time o	of Death	
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19	Funeral			Sex		rs. last birthday)	If Under 1	Year If	Under 24 Hrs.	8. Date of Birt	th Vanal	9. Birtl	nplace (State	or Foreign	
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-	/Medical Examiner		resulting in death)  Due to (or as a consequence of):												
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of	Phys this aldi	2	1 Yes 2 No	11.54		☐ ER/Outpatien				me 5 Resid			fy)		
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Division of Vital Record	i or Atten after deat Director; I in by the	ertification;	4 Homicide determined	200. Flace	ng, etc. (Spe	home, farm, str cify)	eet, factory, of	fice	9	28f. Location (S City or Tow	treet and n, State)	d Number or Rur	al Route Num	ber,	
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	Hospital 24 hours a Funeral C	edicai	29a. Certifier 1 <u>Sertifyin</u> P (Check only one) 2 Medical Exa	miner: On the ba	sis of exami ner stated.	nowledge, death nation and/or in	restigation, in	na tima id my opinio	date and place, on, death occur	and due to the c red at the time, d	auee(s) late and	place, and due t	stated. o the cause(s	;)	
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	Registr	- 0	31. Date filed (Month, Day, Year) JAN 0 9 20	07	Water .	H. Son	1000								

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and little of certifier

JAMES R. MOEN, M.D.

31. Date filed (Warth, Day, Year) 2007

June a Whren no

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1263 NATIONAL

32. Registrar's Signature

HIGHWAY

29c. License number

D33417 (MARYLAND)

MARYLAND

LAVALE

29d. Date signed (Month, Day, Year)

JANUANY 17, 2007

21205

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007  $1\overset{\text{Day}}{3}$ Ray HOWLETT, JR. George January 3:13a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Julia Manor | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 22, 1936 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Mary Tand 70 217-32-7196 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show ?7 is markad other than "natural", or Itams 23s or 28e-f shov traumatic evant, the Nedical Examinar must be invitited at Maryland Washington Hagerstown 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21740 U.S.A. 531 Guilford Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itan any injury or other traumatic evant, the Medical Example 1 ⊠Yes 2 No. If Yes, Give 1957 7958 Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 21 No white Specify: þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0-9 caddy master golf 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin George R. Howlett Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16922 Cavalry Drive, Williamsport, Maryland George Howlett, III 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date January 1 Burial 2 □ Cremation 3 □ Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memerial 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland<sub>21740</sub> 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran attending physician Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed 2 No 1 Yes Hospital or Attanding Physician: 24 hours after death. Funaral Director: After this certificately filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 vursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 Tes 2 🗆 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

5H-0+1 State

To the Hospital within 24 hours a To the Funaral C

29a. Certifier

(Check only one)

1126

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

00

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Hogerstown 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Year)

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

P.0. Division of Vital Records,

Hany, Rada

Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 F Months 093-26-8988 80 6, Director Nov. 1926 Bulgaria Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Modical Examinar must be notified at XXYes 2 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5200 Western Avenue 20815 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: If Yes, Give Year or Dates: Specify: White δ 3\O\Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) Broadcaster US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hiant: If item 27 Is marked other Be Unknown Ruza Draganova 19a. Informant's Name/Relationship (Type, PrintAttorney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eliezer Benbassat/Power of 2330 Tracy Pl. AW Mashington, DC 20008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 1/11/2007 Washington, DC Rock Creek Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Fureral Service License 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock Day /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection 10 Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical the use as i IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has 1 ☐ Yes 2 🗓 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D 0051268 Jan. 4, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lawless MD 8600 Old Georgetown Road Bethesda MD 20814 Nancy P. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 0 9 2007 Registrar DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death

4b. City. Town, or Location of Death

2. Date of Death

2007

4c. County of Death

Montgomery

Jan. 4,

3. Time of Death

9:05

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×.	-	9	Registrar     Decedent's Name	(First, Middle	e, Last)			06	- Illicate or	Deal		2. Date of	of Death	. No. 💪 🔾	101	3. Time of Death
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	Examin		4a. Facility Name (If	not institution	, give street	and number)			4b. City, Town, o	or Location	on of Death			4c. County	y of Death	
			WASHIN  5. Social Security Nu	IGTON A	ADVENT 6. Sex		SPITAL 10 (In yrs. la		TAK		PARK der 24 Hrs.	8. Date o	f Ridh	MONT	GOME	RY place (State or Foreign
	Funeral Director		578-54-8		1 M M 2		64	Yrs.	Months Days	Hour		AUG.	n, Day, Y	1942	Cou	SH. D.C.
-	pu ,		Usual Residence of				100 City	Town or Lo	cotion							10d. Inside City Limits
	faryla shov ed at	ō	10a. State		TO COLOR		Toc. City,			D T 17						1  Yes 2 No
	r the N	rect	MD.  10e. Street and Num		OMERY				10f. Zip Code	KING	7		10g	. Citizen of	What Cou	intry?
	th with	al D	814 F	ROWEN I	RD.				20	910				U.	S.A.	
	tems tems	Funeral Director	11. Maritai Status		Ar	as Decedent med Forces?		. 13.	Was Decedent of I	Hispanic an, Mex	Origin? (Sp	ecify Yes o	or No-		ce - Ameri ck, White	can Indian, , etc.
20	rs afte	by F	1 Never Marrie		11	Yes 2 X Yes, Give	No		1 ☐ Yes 2 🗶 No	Spec	ity:			Specia	fy:	UTTE
-003	2 hou latura			15. Deceden	t's Education			16a. Dece	dent's Usual Occu	pation			16	b. Kind of B		HITE ndustry
7	thin 7 le. lan "n Medl	Completed	(Speci Elementary/Secon	ify only highen ndary (0-12)	7	pletea) ollege (1-4or :	5+)	life.	kind of work done DO NOT use retire	aunng n d)	nost of work	ang				
7	led wi Hygier her th		17 Fathar's Name /	First Middle	(ant)	4		SI	ENIOR DOO		ther's Nam	o /First 14	_	MAYFLC		HOTEL
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. If marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	o Be	17. Father's Name (	ABRAHAN		CH	AIFET2	7		TO. IVIC		RANCE		FOX	•	
≒	2 should and Men is marker sumatic	To	19a. Informant's Na				ALFEIZ		ng Address (Street	and Nu						p Code)
_	1 and 2 Health a tem 27 is other trai		TERYL I	. GOLI	STEIN	/WIFE		814	ROWEN F	D.,	SILVE	R SPE	RING,	MD.	2091	0
2			20a. Method of Disp 1 ☐ Burial 2 ¶		3 □ Remov	al from State	_ CA	nce of Dispo metery, cre	osition (Name of matory or other pla	ice)		Date	20	c. Location	- City or T	own, State
	t. Pa tmer tant jury		4 □ Donation	5 Other (S	pecify)		CI		RS CREMAT  2. Name and Addre		1-8-	-2007	F	RIVERD	ALE,	MD.
ם D	permii Depar Impor any ir once,		21. Signature of Fu		ample	wat	M000	(	CHAMBERS 5801 CLEV	FUNE	ERAL H	IOME &	CRE VERI	EMATOR DALE,	RIUM,	P.A. 20737
			23a. Part1. Enter th shock, or hear	ne disease, or nt failure. List	complication only one cau	ns that cause use on each li	d the death. ne.	Do not en	ter the mode of dy	ng, such	as cardiac	or respirate	ory arrest	t,		Approximate Interval Between Onset and Death
N.	Physician		immediate Cause (I disease or condition resulting in death)		- 4.				SE LARGE	В-СЕ	ELL LY	MPHOM	<b>IA</b>			Onset and Dean
4F	/Medical Examiner		,			Due to (or as ENCEPH										
57		Jer	Sequentially list con if any, leading to im	nditions, mediate	D. —	Due to (or as										
	ecuted ind transit	Examiner	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		U	ACUTE 1			JRE							
0100	icate be executed physician and the burial-transit	al Ey	resoluting in death) E	.aat	l	Due to (or as	a conseque	ence ot):								
00	ficate physis the	edical			d											
Š	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	slcian/Me	IF FEMALE: 23b. Was decedent			yes, outcome □Live birth			⊒Ectopic pregnanc	**/					ate of deliv	*
- -	e deal he att	sicis	in the past 12 1 ☐ Yes 2 ☐		4	□Pregnant a □Unknown			Other (specify)	· y			_	М	onth	Day Year
	hat th od by t detach	Phy	9 ☐ Unknown Part il. Other signifi	icant conditi	ons contribut	ing to death h	out not result	ting in the u	ndertving cause gi	ven in Pa	ırt i.	23e.	Did tohad	cco use con	tribute to	the cause of death?
Ŝ	uires l signe Id be	d by		ERNATRI				<b></b>	, , , , , , , , , , , , , , , , , , ,					2 🗆 No		bably 4 <b>X</b> Unknown
ecords,	s beer s beer	Completed	PERI	NEPHR	C HEM	АТОМА			-				Was an	24b.	Were aut	opsy findings available
ב ב	The la ate ha page 2	omo										1 <sub>D</sub> Y	autopsy performe 'es 2 <b>5</b>	d? No	prior to codeath?	ompletion of cause of 2 No
	clan: entific	Be C	25. Was case referr examiner?	ed to medica		-1.					ace of Deat					
5	hys this al di	To	1 ☐ Yes 2 <b>X</b> 27. Manner of Death		Hospit	a. Date of inju		R/Outpatie	II OLI DON		Nursing Ho			ce 6 □Ot		ify)
	dlng h. : After funer	tion	1 X Natural 2 ☐ Accident	5 Pendir	ig .	(Month, Da		Injury	Wo	rk? Yes 2	□No	zou. Desc	nge now	injury occu	rreu	
<u> </u>	Atter or deal ector by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ		e. Place of in	ury - At hon tc. (Specify)	ne, farm, st	reet, factory, office				on (Stree		ber or Rui	al Route Number,
5	ital or irs afte ral Dir led in	Cert														
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)	1 Certifyir 2 Medicai	Examiner: 0	: To the best On the basis on Ind manner st	of examination	ledge, deat on and/or ir	th occurred at the to exestigation, in my	ime, date opinion,	e and place, death occur	, and due to rred at the	the caustime, date	se(s) and m e and place	anner as , and due	stated. to the cause(s)
	To the vithing to the company of the	Me	29b. Signature and	title of certifie	r				29c. Licen				29d	. Date signe	ed (Month	, Day, Year)
	15		Va	nhe	24				D 6	45	96			1/8	10	+
	(b)		30. Name and addre	<u>ui + 4</u>	, OO C	zar 101	II A	23a) (Type, <b>√                                    </b>	Takom	a?	Park	_ , n	$\sim \mathcal{D}$	20	912	
	Sta Registr		31. Date filed (Mont	AN 0 9	2007	32. degist	rar's Signatu	re K	role							
_		_				-										

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		1- State of Maryland / Department of Healt Certificate of Dea		R	eg. No.	007	01795
Physici	an	1. Decedent's Name (First, Middle, Last)		<ol><li>Date of Deat Month</li></ol>	h Day	Year	3. Time of Death
/Medi		Louie H. Hancock		01	0	2007	0400 M
Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locati	tion of Death			unty of Death	
		Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If year	der 24 Hrs.	0 Data -4 Bists	1	HICIAI	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Vide 1 Yes. Months Days Hou		8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign ntry)
		Usual Residence of Decedent		10-1	- 1950		V. C.
yland		10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
Mar.	ţŏ	MD. Worcester Pocomoke					1 ☐ Yes 2 No
If E. 12.10.000 filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or items 23a or 28s-1 show ant, the Medical Examinar must be notified at	Director	10e. Street and Number 1432 New Bridge Rd. 101. Zip Code 2185	-,	1		of What Cou	
72 hours after death w "naturel", or items 23s	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic		ecify Yes or No-		Race - Amer	
r liter o	듄	Armed Forces? If Yes, specify Cuban, Mex  1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	xican, Puerto	Rican, etc.)		Black, White	
e sin	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1957 — 1☐ Yes 2 128 No Spec	ecity:		Sp	ecity: W	Lite
72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during a	most of working	20	16b, Kind o	ol Business/In	ndustry
Triping	ğ	lifeDO NOT use retired)		ng .		N.A.S	A.
ygien t, tr	ပ္ပ	Elementary/Secondary (0-12) College (1-4or 5+)					
D is D	Be		Nother's Name	(First, Middle, I	Maiden Sur	name)	Hancock
should nd Mer n marke	ပို						
	1 6	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Nu  1432 New Brit	umber or Rura	I Route Number	City or To	wn, State, Zi	Code)
ges 1 and t of Health if Itam 27 or other tr		20a, Method of Disposition 20b, Place of Disposition (Name of		-		on - City or T	
permit. Pages 1 Department of H Important: if its any injury or ot		1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Cemetery, crematory or other place)  Committee Cemetery, crematory or other place)	1-1	2-09		,	
mit. I partm porte.							
		Imanda C-Botto Salyer Farer	el Home	65276	hurch	.57 CAN	23936
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	h as cardiac o	or respiratory arm	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)  a. Intracerebrat he mmo-hage					Onset and Death
/Medical Examiner		Due to (or as a consequence of):					
LAdillilei		Sequentially list conditions, if any, leading to immediate  b. ASCVD  Due to (or as a consequence of):					Days
ted 1st	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury					
be executed sicien and buriel-transit	xar	that initiated events c.  resulting in death) Last Due to (or as a consequence of):				-	
ysicien ne buri	cal						
tificat g phy as th		<u> </u>					
death certifical	N/N	IF FEMALE: 23b. Was decedent pregnant in the sect 13 membrs  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d.	Date of deliv	ery
deat od for	Physician/Med	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)				Month	Day Year
that the de sed by the a	Phy	a Cloukuowu					
uires thet the signed by it do be detect	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Proceedings of the health for the	Part I.				he cause of death?
w require been si should b	ted	Congestive healt faire		1 U Ye	s 2□N	o 3∏Pro	oably 4 Monknown
a law has b e 2 si	Completed			24a. Was a autops	y	b. Were auto	opsy findings available impletion of cause of
sicien: The law scentificate has b irector, page 2 si	ပ္ပ			perform	ned?	death?	2 No
ician certifi ector	Be	Hospital:		(Check only on			
at diri	2	1 I I I I I I I I I I I I I I I I I I I		me 5 Reside			(y)
Affer and	ē	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work?		28d. Describe ho	w injury oc	curred	
or Attending Physicien: The alfer death. Director: After this certificete hi in by the funeral director, page	fica	3 Suicide 6 Could not be		28L Location (St	reet and Ni	umber or Rur	al Route Number.
a effer I Dire	Certification;	4 ☐ Homicide determined building, elc. (Specify)		City or Town	, State)		ar riodio ivalidos,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the buriet-transit	edical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge deal recourse at the time date of the da	le and place, a death occurre	and due to the ea	tuse(s) and ate and pla	Linamer as s ce, and due t	nated. the cause(s)
o the	Me	29b. Signature and little of certifier 29c. License numb	ber	2	9d. Date sig	gned (Month,	Day, Year)
Va,		H00645	34		VI	30	817
10/2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	- 1		DIA		-11
10	1		Sbira	mo	218	0/	
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	7,	, /		~ f	
Regist	rar	JAN 0 9 2007 Marie H. Angeli					

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			For State Registrar		State of	Maryland / D	epartme Certifica			and M	lental Hy	giene Reg. No	2007	0	1796	}
	Dhynini		1. Decedent's Name	e (First, Middle	, Last)						2. Date of De		y Yee		Time of Death	_
	Physici /Medio	al	Mary		Blanche	Johns					Jan 2, 2			1	2:00pm	1
	Examin	er			, give street and num enter of C	umberland		ty, Town, o mberl	r Location o	of Death			. County of De llegany	ath		
	Funeral		5. Social Security N		6. Sex	7. Age (In yrs. last birtl	hday) If Un	der 1 Year	If Under		8. Date of Bi	th	0.8	inthplace	(State or Foreign	ın
	Director		218-64-7		1□M 20 F	90	rs. Month	s Days	Hours	Min.	Oct 3,	1916	6 V	Covintry)		
	yland iow		Usual Residence of 10a. State	10b. County		10c. City, Town		_	-			<u> </u>		10d. lr	nside City Limits	
	e Man ta-f sh	ctor	MD	Alleg	any	Cu	ımberla	nd						1	☐Yes 8☐No	)
	with th	Funeral Director	10e. Street and Nur		D.4.	D. 1.	10f.	Zip Code	24500			10g. Cit	izen of What (	Country?	-	
	ns 23	eral	11/U/ D	alsy Ave	enue, Poto	dent Ever in U.S.	13. Was De		21502		acify Yes or No	)-	USA 14. Race - An	nerican In	dian	
9	or Her	Fun	1 Never Marri	ed 2 Marri	Armed For	ces?	ŧ	pecify Cuba		, Puerto	ecify Yes or No Rican, etc.)		Black, Wh		iorari,	
8	hours tural',	ed by	3 XVidowed		Year or Da	ites:			Specify:					nite		
7.	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-f show fre Madical Examinat court be multind at	plete			t grade completed)		Decedent's U: (Give kind of l life. DO NO)	vork done d vork retired	ation during mosi f)	of worki	ng	16b. Ki	ind of Busines	s/industry	/	
213	ed with	Completed		2	College (1	Hon	nemak	er				Owr	1 Home			
and	I be filed ntal Hygi ed other: event, I	Be	17. Father's Name (		Simmons			ĺ			(First, Middle		,	mma	nc	
E S	should ind Men a marke umatic	ပို	19a. Informant's Na			19b.	Mailing Addre	ss (Street a			rence (l					_
ž	and 2 salth a n 27 is		Erma Lyı			ughter 23	320 Ta	ylor M	ill Ro	ad	Elba	,, .		AL	36323	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "netural; or items 23s or 28s-1 show way injury or other treumatic event, if a Madical Examiner cast be nullised at once.		20a. Method of Disp 1 XBurial 2 [		3 □Removal from S		r, crematory o	r other plac	e)		ate		ocation - City o			
Hin m	it. Pa intmeni intent: injury		° 4 □ Donation	5 Other (Sp	pecify)	Sunset M			i		1/6/2007	Cui	mberlai	nd	MD	
Ba	permit. Departr Importe any inju		21. Signatur 517 u		Licensee	Mi					me, P.A.		N.D. 045			
			23a. Part1 Enter the	ne disease, or or trailure. List of	complications that ca	used the death. Do no	ot enter the m	ode of dying	g, such as	cardiac c	Cumbei r respiratory a	rrest,	IVID 215	Appr	roximate val Between	
	Pnysician		Immediale Cause (	Final	_a C2	runaus.	Arter	1	0750	24				Onse	et and Death	
	/Medical Examiner		resulting in death)	1	Due to (	or as a conse dence of	f):	1							l	7
		Jer	Sequentially list conif any, leading to im	nditions, mediate	b. — Due to (	or as a consequence of	f):									-
	ocuted nd transit	Examiner	that initiated events	injury	c						_					
8760,	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	E E	resulting in death) L	ast	Due to (	or as a consequence of	f):									
687	ficate g phys	edlcal			d											_
Вох	eath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent		23c. If yes, outo	ome of pregnancy th 2 Petal death	3 □Ectopic	ргодларсу				2	23d. Date of de	alivery		
о. В	the att	/sicla	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown			nt at time of death	5 Other (						Month	Day	Year	
۵.	res that the de igned by the a be detached f	/ Ph		cant condition	ns contributing to de	ath but not resulting in	the underlying	cause give	en in Part I.		23e. Did t	obacco u	se contribute	to the cau	use of death?	
rds	w requires been sign should be	ed by									10,	res 2[	]No 3∏F	Probably	4 Donknown	П
Records,	e law re has bee	Completed									24a. Was		24b. Were a	utopsy fir	ndings available on of cause of	,
	i: The licate has, page											rmed? 2 No	death?			
Vital	yelclan: Th is certificate director, pag	o Be	25. Was case referr examiner?	,	Hospital:	patient 2 ER/Outp		Othe			(Check only o					
סר	iding Phye th. After this funeral di	n: To	27. Manner of Death	1	28a. Date o	Injury 28b. Tir		28c. Injury Work	4- NUI		ne 5 🗆 Resid			ecify)		-
Sior	Attending or death.	catlo	1	5 Pending investigation of Could no	ation		М	1 🗆 \	res 2□1	lo						
Division of	i or At after d Direct In by	Certification:	4 Homicide	determi	ned 28e. Place buildin	of Injury - At home, farm g, etc. (Specify)	n, street, facto	ry, office		2	8f. Location (S City or Tox	Street and vn. State)	d Number or P )	iural Rout	te Number,	
	pspital hours inerel y filled		29a. Certifier	12 Certifying	Physician: To the	pest of my knowledge,	death occurre	d at the tim	e, date and	place, a	nd due to the	cause(s)	and manner a	s stated.		-
	To the Hospital or Attending Physician: which 24 hours after death as a first death. To the Funerel Director: After this certifies completely filled in by the funeral director, it	Medical	Unej	2 Medical E	xaminer: On the ba and mann	sis of examination and/	or investigation	n, in my op	pinion, deat	h occurre	ed at the time,	date and	place, and du	e to the c		
	Son Son	2	29b. Signature and	title of certifie	hum		2	9c. License		6		~	e signed (Mon	_		
	6		30. Name and addre	ass of pareon w	no completed cause	of death (Item 23a) (T	vne Print	900	332	80		da	n 2,2	007	· 	_
	nes							Διαρι	ام <i>د</i>	mhai	land M	D 24	502			
	Sta	te	Sunil GI	N 0 5 2	007 32 Re	gistrar's Signature	/ INCIIL	<del>√∨€⊞</del>	<del>io Gul</del>	HUG	iaiiu ivii	<del></del>	JUL			7
	Registr	alf	OH.	0 0 6	100	10 D. K	marke									

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 12:26 P M 2007 Wilbur Thompson January 5, Jefferys /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F 578-01-6144 87 Yrs Director March 8, 1919 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 █No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō 122 Franklin Avenue 20901 IISA 238 Funeral filed within 72 hours after death or Iteme 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify SpecifWhite Š 3 ₩ Widowed 4 Divorced "natural" ted 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Complet (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other the Sales/Manager Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Wilbur M. Jefferys Charlotte T. Thompson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert T. Jefferys/ Son 122 Franklin Avenue, Slver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: If Its
ony Injury or of 9, 1 Surial 2 Cremation 3 Removal from State Jan. Parklawn Memorial Park 4 □ Donation 5 □ Other (Specify) 2007 Rockville, Maryland 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home 500 University Blvd, W., Silver Home Inc Spring, MD 20901 Canto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician /Medical resulting in death) Davs Examiner Sequentially list conditions, any, backing to him classicause. Enter Underlying Cause (Disease or injury Pneumonia Days nnsearrance of Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) burial-P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f I□Yes 2□No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊠Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2√€ No 3□ DOA 2 ER/Outpatient this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier and manner stated. the th 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 D32332 January 5, 2007 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gupta, M.d 9801 Georgia Avenue, #220, Silver Spring, MD 20902 Suresh K.

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 9 2007

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien® 0.0.7

			For State Registrar		-		tificate of	eaith and M Death		Reg. No.		U1/30
	Physici		1. Decedent's Name (First, Middle, La: Louis A. Jacob						2. Date of De Month Januar	Day	Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give				4b. City, Town, or	Location of Death	Januar	4c. County o		12:07 <sup>p M</sup>
	LXaiiiii		Suburban Hospita	1				Bethesda			Mont	gomery
	Funeral Director		5. Social Security Number 6. S		ge (In yrs. last bir 79	thday) Yrs.	II Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April 2	y, Year) 5, 1927	9. Birthp Coun Oh	lace (State or Foreign try) io
	nyland how		10a. State 10b. County		10c. City, Town	n or Lo	cation				1	Od. Inside City Limits
	Ba-f e	cto	Maryland Montgom	ery		Ke	nsington					1 ☐ Yes 2X☐ No
	ith with th 23a or 28 ust be no	ral Director	10e. Street and Number 9918 Old Spring	Road			10f. Zip Code	20895		10g. Citizen of Wh		stry? SA
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Itame 23a or 28a-f show any injury or other traumatic event. The Madical Examinar must be notified at once.	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 D Yes 2 1 If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Black, Specify: 1	, White,	etc.
Maryland 21215-0036	ithin 72 h Je. han "natu Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)			(Give	ent's Usual Occupa kind of work done of OO NOT use retired	<i>luring</i> most of work	ing	16b. Kind of Bus	iness/Ind	dustry
2	lled w tygier her ti		17. Father's Name (First, Middle, Last)	4	Sou	the	ast Asia	Libraria				Congress
and	ad of	Be						18. Mother's Name	,		)	
2	should nd Me mark matic	ြ	Louis Albert Ja  19a. Informant's Name/Relationship (		19b	Mailin	n Address (Street a	Ma D and Number or Rura	el Harr		tate Zin	Codel
Z	lith ar 27 is r trau		Leonard Rubin/ P	**			•	oad, NW,				
altimore,	Pages 1 ar		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specification)				sition (Name of natory or other place n Crematory	, Janua	ery 5,	20c. Location - C		wn, State , Virginia
Balti	permit. Departm Importe any Inju		21. Signature of Funeral Service Licer			22 F 5	Name and Address rancis J 00 Unive	s of activins	007 Funera d, W.,	l Home In Silver S	nc. prin	g, MD 2090
			23a. Part 1. Enter the disease, or com shock, of heart failure. List only	plications that caused	the death. Do r	not ente	or the mode of dying	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
86 Cours 68760,	eath certificate be executed xx ettending physicien and for use as the burial-transit and	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Hypa	a consequence of	50	25 24/					
.0. Box 6	The law requires that the death certifi site has been signed by the estending page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date Monti		ry Day Year
20 rds, P	w requires that been signed t should be deta	d by PI	Part Other significant conditions of Toj Tajz Hyper	ontributing to death b	ut not resulting in	the un	derlying cause give	n in Part I.		obacco use contrib 'es 2 □ No 3		e cause of death? ably 4 ⊟Unknown
4/07 (2.0 Vital Records	: The law requ cate has been page 2 should	Complete	Lower Extremi	ty Ham	10/2614	_			24a. Was autop perfor	med? de:	ere autor or to con ath? ] Yes	osy findings available inpletion of cause of
₹ <del>/</del>	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			1 04	26. Place of Death	Check only o	ne)		
7.2	ing Phyen.	ıtlon; To	1 Yes No  27. Manner ol Death  Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatie  28a. Date of Injui (Month, Da)	ry. 28b. T	tpatient ime of njury	28c. Injury Work	4   Nursing Ho		ence 6 Other ow injury occurred		)
Division	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, far c. (Specify)	rm, stre	et, factory, office		28I. Location (S City or Tow	treet and Number n, State)	or Rurai	Route Number,
	To the Hospital or At within 24 hours after o To the Funerel Direct completely filled in by	Medical	29a. Certifying Ph	ysician: To the best on the basis of and manner sta	t examination and	, death d/or inv	occurred at the time estigation, in my op	e, date and place, sinion, death occurr	and due to the d ed at the time, d	cause(s) and manr date and place, an	ner as sta d due to	ated. the cause(s)
•		×	29b/Signary and title of Certifie	Her D	OFAC	P	29c. License			JANUARY		
			GAMY 8. IXAFFEL	completed cause of d	tel 5	Type, f	Print) W. Cedar	839 Lane #2	2024 B	Hansa,	118	20814
1	Sta Registr		31. Date filed (Month, Day, Year)	32 Gegistra	ar's Signature	No.	sels?					

07-00547 Mark Kessler, Jr.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

viant recording o		1- For State Registrar  1- For State Certificate of Death	Reg. N	. 2007 0179									
Physici			Date of Death	3 Time of Death									
Medical Exami	iner		Month Day January 20, 2										
- marine		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Memorial Hospital Cumberland		4c. County of Death									
<u> </u>			0 D-4(D) II ii	Allegany									
Funeral Director		Months Days Hours Min		M/DD/YYYY) 9. Birthplace (State or Foreign									
		216-49-1829 1 Mm 2 F 9 Yrs. World Days 110 Mm.	Mar 14,	1997 Country) MD									
â		Usual Residence of Decedent  10a. State 10b County 10c. City, Town or Location		10d. Inside City Limits									
0 w a				1 X Yes 2 No									
ith the Maryland 23a or 28a-f show any notified at once.	Director	MD Allegany LaVale  10e. Street and Number 10f, Zip Code	100.0	Citizen of What Country?									
e Man or 28,	ě			•									
ith th		1 1817 Cash Valley Road 2 1502  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec		USA									
ath w items	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric		14. Race - American Indian, Black, White, etc.									
iter de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: White									
urs al Itural	d b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of world)		b. Kind of Business/Industry									
72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired	1)										
036 r tha 4edic	립	3 None		N/A									
5-0 Hygid		17. Father's Name (First, Middle, Last)  18. Mother's Name (F	ırst, Middle, Maide	en Surname)									
1215-0036 Id be filed within 72 hours a fental Hygiene narked other than "matura" event, the Medical Examin	8	Mark John Kessler, Sr. Pam Free											
O 2, should and Ma is ma	잍	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural)											
nd 2 salth a salth a 27 raum	- 1	Pam Freeman—mother   11817 Cash Valley Road   20a Method of Disposition   20b Place of Disposition (Name of cemetery   120b Place of Disposition (Name of cemete											
Ore, of He of Her there		1 X Burial 2 Cremation 3 Removal from State crematory or other place)		c. Location - City or Town, State									
im Pag ment tant: or of	Į		4/2007	Cumberland, MD									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign of Funeral Service Licentee Scarpelli Funeral Ho											
	-1	108 Virginia Ave; Cu											
Physician /Medical		23. Far I. Enter the disease, or colliplications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.		Between Onset and									
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)  a. Seizure disorder status post brain tumor compliance of the condition resulting in death)	ated by pr	neumonia Death									
	- 1	but to (or as a consequence of).											
-36-	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated											
is Edin	Exa	events resulting in death) Last  Due to (or as a consequence of):											
execut in and if - tra		X UNPENDED AMENDED OCE 2 /00 /07 HTD											
50, te be ex ysician burial	Medical	#23a,27,perme,g865,3/30/0/ TI											
876 tificar ng ph as the		23b. Was decedent pregnant in the		23d. Date of delivery  Month Day Year									
Sox 68 leath certiff	icia	Pregnant at time of death 5 Other (Specify)											
Bo the a	Physician	1 Yes 2 No 9 Unknown 9 Unknown											
that the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		to use contribute to the cause of death?									
S, F uires I n sign	ed k		1 Yes 2	No 3 Probably 4 ₩ Unknown									
ords, w requir	olet		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of									
Reco	Completed by		performed 1 ✓ Yes 2										
an: T an: T entific tor, p	BeC	25 Was case referred to medical 26.Place of Death (Check only											
Vita sysicia this cel	0	examiner?  1 Ves 2 No  Hospital 1 Inpatient 2 ER/Outpatient 3 DOA  Other  Nursing H	lome 5 Resid	dence 6 Other:									
n of ding Ph		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28	d. Describe how in	njury occurred									
ion tendi for: /	읉	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)  1 Yes 2 No											
ViS or At fter d Direct in by	ij			and Number or Rural Route Number, City									
Divis pital or At ours after d eral Direc	Certification:	4 Homicide determined (Specify)	or Town, State)										
e Hos 24 ho e Fun etely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the	e time, date and p	place, and due to the cause(s)									
- > - 9	Σ	29b. Signature and title of certifier 29c. License number	290	I. Date signed (Month, Day, Year)									
		O.C.M.E.	Ja	nuary 21, 2007									
	1	30. Name and address of perso, who completed cause of death (Item 23a)											
		Jack Titus MD Denuty Chief Medical Examiner 111 Penn Street Baltimore MD 2120	)1										
P													
		48 - A 4 1 // / A 4 M A											

			for State Registrar	State of M	narylano		rtificate of		ina Mentai	Reg. N	<u> </u>	7 01800
	Disconint		1. Decedent's Name (First, Middle	, Last)					2. Date of		ay Y	3. Time of Death
	Physici: /Medic		MARJORIE VIR	RGINIA LAI	KIN				JANU	ARY .	11 200	07 8:16 P M
	Examin		4a. Facility Name (If not institution,		r)		4b. City, Town, o			4	c. County of	
			331 NORTH MAIN				If Under 1 Year	BOONS If Under		4 Dieth		HINGTON
п	Funeral		,	6. Sex   7. A 1 □ M 2 ☑ F	Age (In yrs. la:	st birthday) Yrs.	Months Days	Hours	Min. (Mont	of Birth h, Day, Yea		Birthplace (State or Foreign Country)
	Director		219-36-2796 Usual Residence of Decedent		94				JUNE	16,	1912	PENNSYLVANIA
	/land		10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Man I eh	ţo	MARYLAND WASH	HINGTON			BC	ONSBO	RO			1 X Yes 2 □ No
	n 188	irec	10e. Street and Number				10f. Zip Code			10g. (	Citizen of Wha	at Country?
	th wit	a	331 NORTH MAIN	STREET			2	21713			U.S	.A
	ems	Funeral Director	11. Marital Status	12. Was Deceder Armed Forces		. 13.	Was Decedent of H	lispanic Orig	gin? (Specify Yes	or No-		American Indian, White, etc.
36	or it	F.	1 Never Married 2 Marri	ed 1 Tes 25	₹ No	1	1 ☐ Yes 2 ☑ No				Specify:	
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f ehow dical Examinar must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates	s: 	16a Daga	dent's Usual Occup	ntion		165	Kind of Busin	WHITE
15	"nat	Completed	15. Decedent (Specify only highes	t grade completed)		(Give	kind of work done  DO NOT use retire	during most d)	t of working	100.	KIIIQ OI DUSII	less/Industry
12	filed within Hygiene.  Other then "ant, the was	Ę,	Elementary/Secondary (0-12)	College (1-4o	r 5+)		HOMEM				OWN HO	OME
	filed Hyg othar ant,	BeC	17. Father's Name (First, Middle, I	1			1101111		r's Name (First, M	iddle, Maide		J111
Maryland	d la b	To B	CHARLES BERRY I	BEALL				LAUR	A VIRGIN	IA JOI	INSON	
ary	should I and Meni marke umatic	-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address (Street	a <i>nd Nu</i> mbe	or or Rural Route N	umber. City	or Town, Sta	ate, Zip Code)
	1 and 2 Health a tem 27 is		ELEANOR LAKIN/I	DAUGHTER		121	LAKIN AVE	NUE,	BOONSBOR	O, MAI	RYLAND	21713
Baltimore,	permit. Pages 1 ar Department of Hea Important: if item any injury or otha once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Domoval from Stat	col	ice of Dispo metery, crei	osition (Name of matory or other pla	ce)	Date	20c.	Location - Cit	ty or Town, State
Ĕ	Pages nent of I ant: if its ary or o		'4 □Denation 5 □ Other (Sc			NSBOR	O CEMETER	RY O	1/15/200	7 BO	ONSBOR	O, MARYLAND
att	permit. Pag Department Important: I any injury o		21. Signature of Fuheral Service I		M. De	22	2. Name and Addre	ss of Facilit	7606			al Pike
<u> </u>	89 2 2 2		and III	lear					ROOU		, Mary	land 21713
			23a. Part1. Enter the diseas, or shock, or heart failure. List	complications that caus only one cause on each	ed the death. line.	Do not en	ter the mode of dyir	ng, such as	cardiac or respirat	ory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Par	. Ki							Onset and Death
					1 1	D > 0	n 5	101	5 Ca10			10 years
	/Medical		resulting in death)	Due to (or a	as a conseque	ence of):	7.5	Di	s ease			10 years
	/Medical Examiner	L		b			N.3	Di	s ease			loyears
	Examiner	iner		b	as a conseque		N 3	_ D 1	s ease			lugears
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Records, P.O. Box 6	e law requires that the death certificate be executed that been signed by the attending physician and that 2 should be detached for use as the burial-transit that the control of the cont	by Physician/Medical	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2	b. Due to (or a d. Due to (or a d. 23c. If yes, outcom	as a consequence of pregnan 2   Fetal at time of dea	ence of): ence of): ecy death 3[ ath 5[	Other (specify)	y	23e.	Did tobacci 1 ☐ Yes  Was an autopsy	Month  o use contribu  2 No 3 (  24b. We prior dea	of delivery Day Year  ute to the cause of death?  Probably 4 Unknown  re autopsy findings available in to completion of cause of th?
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Division of Vital Records, P.O. Box 6	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or a c. Due to (or a d. Due to (or	as a consequence of pregnan 2   Fetal at time of death (specify)   Stoff my known of the control	ence of):  ance of):  cy death 3E ath 5E ting in the u  cR/Outpatier 28b. Time of Injury me, farm, st  viedge, deat on and/or in	other (specify)	26. Place 26. Place Per: 4 \( \text{Nu} \) Nu ry at rk? Yes 2 \( \text{Imperior} \)	23e.  24a.  1 Of Death (Check or sing Home 5 X 28d. Desc City of City of Check of City of Check of City of Check of City of Check of City of Check of City of Check o	Did tobacco  1  Yes  Was an autopsy performed (for 2)  Residence ribe how in on (Street or Town, State at a 29d. C.  JAN	Month o use contribut 2 No 3   24b. We prior dea 1   6 Other jury occurred and Number ate) (s) and mannind place, and Date signed (NUARY 1	of delivery Day Year  ute to the cause of death? Probably 4 Unknown  re autopsy findings available of to completion of cause of th? IYes 2 No  (Specify)  or Rural Route Number,  er as stated. If due to the cause(s)  Month. Day, Year)
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DHMH 17 Rev 1/2001

			1 - For State Registrer AMEND#19boer IV	State of Marylan	0.		of Health and	Mental H	ygiene Reg. No.	1007	01801
	-		1. Decedent's Name (First, Middle, Las					2. Date of D			3. Time of Death
	Physici	_	GAIL	PATRICIA	LAMK]	ΓN		JAN.	7,	y Year 2007	8:45 A M
)	/Medic Examin		4a. Fecility Name (If not institution, give		13111111		Town, or Location of De			County of Dea	
	_Adiiiii		LARKIN CHASE				BOWIE			PRINCE	GEORGES
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under	1 Year If Under 24 H		irth		thplace (State or Foreign ountry)
	Director		220-48-5100	□M 21X1F 64	Yrs.	Months	Days Hours Mi	NOV.	6, Year)	42 WA	ASH. D.C.
	<u>o</u>		Usual Residence of Decedent								
	how i		10a. State 10b. County	10c. Cit	ty, Town or L	ocation					10d. Inside City Limits
	e Ma	cto	MD. PRINCE	GEORGES		MITC	HELLVILLE				1√2 Yes 2 □ No
	e 22 a	Slre.	10e. Street and Number			10f. Zip	Code		10g. Citi	izen of What C	ountry?
	72 hours after death with the Maryland Insture!; or Iteme 23e or 28e-f show dical Examinat must be notified at	Funeral Director	4008 ROMSEY D	R.			20721			U.S.A.	
	e de c	lue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decede	ent of Hispanic Origin? Ify Cuban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Ame Black, Whi	
9	or it	Y.	1 Never Married 2 Married	1 □ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2				Specify:	120
Ö	ure!	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						WH	HITE
21215-0036	nat	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	s kind of worl	I Occupation k done during most of w	vorking	16b. Ki	ind of Business	/Industry
12	within ene. then "	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	шe.	DO NOT us	·			NONE	
	e filed velled vother to		9   17. Father's Name (First, Middle, Last)			NON	1	ame (First, Midd	le Maiden	NONE	
and	od of the the	Be					10. Would 3 14				7
2	should nd Mer marke marke	ဥ	JOSEPH	BREWER	10h Maili	in a Address	(Street and Mumber or		OU bas Cibra	KENNEDY	
Maryland	d 2 should be filed within 72 hours after death with the Marylan than Mental Hygiene. 77 is marked other than "natureli, or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (7		1451	a tuxer	(Street and Number of It Mobile E				
	f Heattl		SHARON DEGE/SI		Place of Disp	77 A 4 - 1 - 1 - 1 - 1 - 1		Date		.AN , MD . ocation - City or	
Baltimore,	t of h		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐	Removal from State	cemetery, cre	matory or ot	her place)	Daid	200. E0	ocation - City of	TOWIT, State
Ë	permit. Pages Depertment of h Important: If ite eny injury or of ongs.		4 □ Donation 5 □ Other (Specify	) CH	IAMBERS			-2007	_		ALE, MD.
32	Depermit Deper Impor eny in		21. Signature of Funeral Service Licen	2	2	2. Name and CHAMBE	Address of Facility RS_FUNERAL	HOME &	CREMA	TORIUM.	P.A.
_	<u> </u>	0 1	W.W.Chu		10091 5	5801 C	LEVELAND AV	/E., RIV	ERDAL	E, MD.	20737
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caused the deat one cause on each line.	th. Do not en	ter the mode	of dying, such as card	ac or respiratory	arrest,		Approximate Interval Between
T E	hysician		Immediate Cause (Final disease or condition	. CHRONIC OBS	TRUCT1	LVE PU	LMONARY DIS	SEASE			Onset and Death YRS.
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89	death certifica e ettending ph id for use as th	Physician/Med	IF FEMALE:								
Вох	eath certific ettending pl	an/l	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pre	egnancy			23d. Date of de	
Э.	ed fo	20	in the past 12 months? 1 ☐ Yes 2 🂢 No	4☐Pregnant at time of d		Other (spe				Month	Day Year
P.0	The law requires that the de ste hes been signed by the e pege 2 should be detached	چ	9 Unknown						_		
s,	es the igned be det	ρ	Part II, Other significant conditions of	ontributing to death but not res	sulting in the u	underlying ca	iuse given in Part I.	23e. Dio	I tobacco u	use contribute t	o the cause of death?
p.	w requir been si should							- 1	Yes 2	□No 37∏P	robably 4 □Unknown
Record	hes be	Completed						24a. Wa	s an opsy		utopsy findings available completion of cause of
Œ	The The pege	E						per	formed? 2tv No	death?	2 No
		O	25. Was case referred to medical				26. Place of D	eath (Check only			
>	× ∞ 0	9	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DO	A Other: 4 X Nursing	Home 5 □ Re	sidence	6 □Other (Spe	ecify)
		Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28	Bc. Injury at Work?	28d. Describe			
Division	Attending I r death. ector: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	,,	М	1 ☐ Yes 2 ☐ No				
	or Attendation of the Control of the	5	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h	ome, farm, st	reet, factory,	, office	28f. Location	(Street an	d Number or R	ural Route Number,
۵	s after s after of Dire	Certification:		building, sic. topoci	97			Cay or .	om, biale	,,	
	Mospital or 24 hours afte Funerei Dir etely filled in		29a. Certifier 11 Certifying Ph	ysician: To the best of my knowniner: On the basis of examina	owledge, dear	th occurred a	at the time, date and pla	ce, and due to th	e cause(s)	and manner a	s stated.
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	one) 2 Medical Exam	and manner stated.	ation and/or if	ivestigation,	in my opinion, death oc	curred at the time	, date and	place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and http of certifier			29c.	License number		29d. Dat	te signed (Mon	th, Day, Year)
	V		MATALMI	<b>S</b>			D41978		JA	AN. 8,	2007
	•		30. Name and address of person who d	completed cause of death (Iter	т 23а) (Туре	, Print)					
		1 8	NADER TAVAK	OLI, M.D.	4000	MITCH	IELLVILLE RI	D.#312,	BOWIE	E, MD. 3	20716
	Sta	ite	31. Date filed (Month, Day, Year)	32 pistrar's Signa	ature	1.0.					/
	Registr	ar	JAN 0 9 20	307 Balliers .	Mr. Att	TENEL!					/

07-00137 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alanna Marie Lake State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ dent's Name (First, Middle Last) 2 Date of Death Month Day January 5, 2007 Medical Examiner 1421 hrs 4a Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number Date of Birth(MM/DD/YYYY 6. Sex . Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 9 Birthplace (State or **Funeral** Director Months Davs Hours Min 218 39 956 10 M 2 1 Country) Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits s 23a or 28a-f show a notified at once. Yes 2 Lino should be filed within 72 hours after death with the Maryland Director 10e Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S 14. Race - American Indian, Black Armed Forces? Never Married Yes Widowed Divorced If Yes, Give Year Yes 2 No specify. "natural", ş r Dates 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) it: If item 27 is marked other than other traumatic event, the Medical Baltimore, MD 21215-0036 STUDEN of Health and Mental Hygiene 17. Father's Name (First, Middle, Last Be 101+1 ို 19b. Mailing Address Place of Disposition (Nar 20c. Location - City or Town crematory or other place) CREMATO Burial 2 Cremation 3 Removal from State Donation 5 Other Specify. 21 Signature of Funeral Service Licensee Physician Part I. Enter the disease, or complications that caused the death. Do not enter failure List only one cause on each line. Between Onset and Death /Medical a Head and Right Shoulder Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Yea past 12 months? Pregnant at time of death Other (Specify 1 Yes 2 No 9 V Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? ξ Yes 2 V No 3 Probably 4 Completed this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? Yes 2 V No Yes No 25. Was case referred to medical 26.Place of Death (Check only one Be Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes 2 28a Date of Injury (Month Day Year) Jan 5, 2007 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Driver auto auto collision Natural 1337 hrs 5 Pending 1 Yes 2 ✔ No hours after death To the Funeral Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Sangamore Road at Sangamore Court, Bethesda, MD determined (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day Year)

Ling Li, MD

MV

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

2007

**ORIGINAL** 

Registrar's Signature

29c License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 6, 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician CONQI January 2007 /Medical City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ber ? Rehabilitation NURSING WORCE 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-29-1 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F 219-07-7258 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Yes 2 No lorceste. Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number U.S.A 218 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □ Yes 2 No Jeonard, William C. Baltimore, Maryland 21215-0036 Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) MAGEE and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be MON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health as Important: If item 27 is any Injury or other trau once. 9621 Seahawk Kd (wite Berlin, md 2181 Leonard Leonard, 20a. Method of Disposition 1 ▶ Burial 2 □ Cremation 3 □ Removal from State Place of Disposition (Name of cemetery, crematory or other place) 5 3/07 22. Name and Address of Facility Bennie Smith 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service W. Isabella Street SALISBURY, and 21801 FUNERAL HOME 23a. Part1. Ent to he dise shock, or heart failu or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Coset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** heoscheotte ardioV ks when eus /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has I rector, page 2 s autopsy performed? Yes 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 Tes 2 No ours after death. neral Director; A filled in by the ft 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year)

200

State Registrar

JAN 0 9 2007

Victistos Borodulia

31. Date filed (Month, Day, Year)

32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 6:49 PM Lima 2007 Gunnar January /Medical 4c. County of Death 4a. Facility Name Uf not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) rs. last birthday) If Under 1 Year | If Under 5. Social Security Number 7. Age (17) Birthplace (State or Foreign Country) **Funeral** Days Min 1 MM 2□ F Yrs. 57 Director 10 16/1949 469-98-5439 Norway Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show notified at 1 ☐ Yes 2 No Director MD Frederick 28a-f New Market 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be 11258 Crickenberger Road 21774 USA

14. Race - American Indian. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physician Health Care marked other Ith and Mental Hvr 7 Is mark 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arne Lund ပ Anine Froehlich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra Mary Elizabeth Smith Wife 11258 Crickenberger Rd. New Market MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/17/2007 Smithsburg, MD Smithsburg Crem. 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Foneral Service Licensee M00255 106 East Church St. Frederick. MD 21701 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final year **Physician** Metastatic disease or condition resulting in death) Gastric Cancer /Medical Due to (or as a consequence of): Examiner dysfunction week Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine weeks dys function be executed Liver and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9□Unknown 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 2☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 TYes 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury 28h. Time of al or Attending P s after death. Il Director: After t d in by the funera Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760 P.O. Division or Vital Records,

within 24 hours a To the Funeral L Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of cerm MD D 0064337 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Woife Street, Baltimore, 20 Hopkins Hospital, Zeshaan Rasheed Johns Registrar's Signature State Registrar DHMH 17 Rev 1/200 **ORIGINAL** 

			For State Registrar	State	of Marylan		artment of H rtificate of L			giene Reg. No.	007	01805
			1. Decedent's Name (First, Midd	lle, Last)					2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia /Medic			RUT	H CATH	ERINE 1	MOLES		JANUAF			9:15 P.M
	Examin		4a. Facility Name (If not institution	on, give street and n	umber)		4b. City, Town, or	Location of Deat	h	4c. Co	unty of Death	
			ST. CATHERINE	'S NURSING	CENTER		EMMITS	BURG		FR	EDERICK	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	th y, Year)	9. Birthpl Coun	ace (State or Foreign try)
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	DC *		Usual Residence of Decedent  10a. State 10b. Count	<i>y</i>	10c Cit	y, Town or Lo	cation				10	Od. Inside City Limits
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	er de	une	11. Marital Status	Armed F		.5.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (s in, Mexican, Puer	to Rican, etc.)	14.	Black, White,	
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7 5	il Hygien other th		17. Father's Name (First, Middle	, Last)	,	1		18. Mother's Na	me (First, Middle,	Maiden Sui	mame)	
<u>a</u>	d be ental ked o	To Be	CHADIEC	EDWARD SV	JODE'			HELEN	I ELIZABI	erh we	TKERT	
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9	ages ant of t: If t		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		n State		natory or other plac	1	c 1/22/0	7 GETTO	rveriide	, PA. 17325
	permit. Page Department of Important: If any njury or once.		21. Signature of Funeral Service		1		2. Name and Address		SKILES FU			, IN. 17523
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	_		23a. Part Enter the disease, of show, or heart failure. Lis	or complications that	caused the deat							Approximate Interval Between
	cate be executed by Medical Examiner transit the private transit the private transit t	dical Examiner	Immediate Cause (Final dise is or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Studies	o (or as a consequence of the co	uence of):  unnce of):  Unnce of):	rtery	DISAG	is a	inds	2	1 xeak 370 0xea(2)
	law requires that the death certificate se been signed by the attending physion 2 should be detached for use as the I	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live 4 ☐ Preț 9 ☐ Unk		Il death 3[ leath 5[	Ectopic pregnancy Other (specify)			23d	. Date of delive Month	ry Day Year
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Records,	sician: The law re s certificete hes be lirector, page 2 sho	Completed	MATOR	DERRI	HEA	RT;	FAILU.	RE	24a. Was autor perfo		t4b. Were autor prior to con death? 1 □ Yes	osy findings available inpletion of cause of
VITAI	tor, p	Bec	25. Was case referred to medic	al				26. Place of De	ath (Check only o			
>	ysici is ce direc	TOE	examiner? 1 ☐ Yes 2 🙀 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 X Nursing	Home 5 Resi	dence 6	Other (Specify	')
0	g Ph er th eral		27. Manner of Death		e of Injury nth, Day Year)	28b. Time o	f 28c. Injun	y at	28d. Describe	how injury or	ccurred	
<u></u>	ndin ath. e fur	atlo	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ing (7076 tigation	min, bay roal,	,ury		Yes 2 □ No				
DIVISION	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minod 200. Place	ce of Injury - At h ding, etc. (Special	ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and N wn, State)	lumber or Rura	l Route Number,
	ne Hospit 24 hour ne Funera Hetely fille	edical (	29a. Certifier 1 Certify (Check only 2 Medical	ing Physician: To the Examiner: On the and ma	ne best of my kno basis of examina inner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and date and pla	d manner as stace, and due to	ated. the cause(s)
	within To the comp	ž	29b. Signature and title of certifi	er		0	29c. Licens	e number		29d. Date s	igned (Month, I	Day, Year)
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			30 Name and address of person	n who completed car	use of death (Iter	n 23a) (Type.	Print)	1	21-1	75	w. al	lainst
	10		BONITA T.	ICREI	UPEC	- FOR	TIERI	DO P	umi	TSBO	uRO,	upany
2	Sta Registr		31. Date filed (Month, Day, Yea		Registrar's Signa	ature	,		,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 17 2007 Bertha Dougherty Michael 7:00 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth Mar 21, 1918 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 📉 F 88 Maryland 214-10-2237 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at Maryland Frederick Frederick 1 Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 315 South Market Street 21701 U.S.A. filed within 72 hours after death v Hygiene. Ither than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ Specify: White 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home . Pages 1 and 2 should be filed wi fment of Health and Mental Hygier tant: If item 27 is marked other th jury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Levin Rice Bertha Alice Dougherty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dellwood W. Michael, Son 315 South Market Street, Frederick, MD 21701 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or Mt Olivet Cemetery Jan 22, 2007 Frederick, Maryland 4 □ Donation 5 □ Other (Specify 21. Sign ture Funeral Service Lin 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, MD 21701 M00706 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 121 gr ngo **Physician** Cormary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and I for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate ha perform 2 NINO Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directorial di 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

orpa

MD.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Austin Pearre,

31. Date filed (Month, Day, Year) JAN 2 4 2007

709689

300 West Ninth Street, Frederick, Maryland 21701

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			1 - For State Registrer	State of M	larylan		artmen tificat			and M		giene Reg. No.	007	018	0.7
	Physici	an	1. Decedent's Name (First, Middle, Last								2. Date of Dea	ath Day	Year	3. Time o	of Death
	/Medio		Micheal Anthony	Mucci							January		2007	4:40	рМ
	Examir	ner	4a. Facility Name (If not institution, give						Location o	f Death		4c. 0	County of Dear	th	
			Montgomery Genera  5. Social Security Number 6. Se			last birthday)	If Under	Olne	y If Under 2	D4 Hrs	O Data of Die		Montg		
	Funeral Director			3m 2□F	85	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day		_ Co	thplace (State ountry)	
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	rrylan show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside C	City Limits
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	vith th	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Co	ountry?	
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	72 hours after death with the Maryland Instural; or Iteme 23a or 28a-f ehow dical Examiliar must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ★ Married	<ol> <li>Was Decedent Armed Forces</li> <li>1 ∑Yes 2 □</li> </ol>	?	.5.	Yas Deced Yes, spec	ify Cubar	spanic Orig n, Mexican,	n? (Spe , Puerto	cify Yes or No- Rican, etc.)	1	<ol> <li>Race - Ame Black, Whit</li> </ol>		
99	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		47	I ☐ Yes 2	2□ <b>x</b> No	Specify:			5	Specify:Whi	te	
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Pages of the mean and the many and the standards. If the many is a cristal server is a server on the traumatic event, the Medical Examination read be notified at once.			•							l Route Numbe	. ,			
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2	ages ant of t: # if		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	, a	emetery, cren te of I	natory or of	ther place	1	Jan	. 12,				
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			23a. Part1. Enter the disease, or compl	cations that cause	The death	. Do not ente	er the mode	e of dying	, such as o	cardiac o	r respiratory ari	est,	r ppri	Approxima	te
	Physician	h	shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each i	Me.	c of	dia	1 :	Inin					Interval Bei Onset and	
	/Medical		resulting in death)	Due to (or as	a consequ		the	41	V6A.						
	Examiner		Sequentially list conditions												
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	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last												
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87	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical													
× 6	res that the death certific igned by the attending p be detached for use as	/Me	IF FEMALE:	3c. If yes, outcome	of pregna	ncv									
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o.	the d	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			ourier (spe	JONY)							
٠ <u>.</u>	s that ned b	by Pl	Part II. Other significant conditions con	tributing to death b	out not resu	Ilting in the un	derlying ca	use giver	n in Part I.		23e. Did to	bacco use	contribute to	the cause of c	death?
ğ	w require been sig should b	ed b									1 🗆 Y	es 2	Mo 3 □ Pro	obably 4 🗆	Unknown
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æ	The lav	Completed									autops	ned?	prior to death?	ompletion of a	ause of
Division of Vital Records,	hysician: The la his certificete ha: I director, page 2	Bec	25. Was case referred to medical						26. Place	of Death	(Check only or	2 200	1 L Yes	2□ No	
<u> </u>	or Attending Physician: Ifter death.  Director: After this cartific in by the funeral director.	To	examiner?	ospital:	ent 2 🗆 E	ER/Outpatient	3 □ DO	Other	~		ne 5 Reside		Other (Spec	ufy)	
_ _	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28	Bc. Injury		-	8d. Describe ho			,,	
<u>s</u>	ttending death. ctor: After / the funer	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М	1 🗆 Y	es 2□N	0					
$\leq$	after deatl Director:	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At hor c. (Specify	me, farm, stre	et, factory,	office		2	8f. Location (Si City or Town	reet and i n, State)	Vumber or Ru	ral Route Num	ber,
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	To the Hospital or All within 24 hours after of To the Funeral Directompletely filled in by	edicai	29a. Certifier (Check only one)  Certifying Physical Cartifying Physical Examination (Check only one)	er: On the basis o and manner sta	i examinati	vledge, death ion and/or inv	occurred a estigation,	it the time in my opi	e, date and nion, death	place, a occurre	nd due to the ca d at the time, d	ause(s) ar ate and pi	nd manner as lace, and due	stated. to the cause(s	;)
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: 1-	+1		Mulh	~~	_		1	COE	5319	2		16	107		
6			30. Name and address of person who co	mpleted cause of d	leath (Item	23a) (Type, F	Print)	lin	Nanh.	10 /	olivey	1/1	200	(2)	
	Sta		31. Date filed (Month, Day, Year)	32 Registr	ar's Signat	ure	110	up	UVYIV	7	rivey	MD	aux	27	
	Registra	ar	JAN 0 9 2007	Bergun	1	600	1								

а	mmended	l #	5 per f.h. 1/10/200 Please 1	ype or Print in	Black Indelil	ole ink. i	Ensure Al	I Copies	Are Legible.	Carroll Co.
			1 - For State Registrar	State of Marylar		ent of Hea a <i>te of De</i>		_	200	<b>wj1</b> 7   0 808
	Dharia		Decedent's Name (First, Middle, Last)				out.	2. Date of De		3. Time of Death
	Physic /Medi		William T.	McCauley				Jan.	Day Year	7 5:00P
	Examir	ner	4a. Facility Name (If not institution, give Beverly Healt			-	ocation of Death		4c. County of Dea	ath
	Funeral	6	5. Social Security Number 6. Se	7. Age (In yrs.	. last birthday) If Un		f Under 24 Hrs.	8. Date of Bir	th a Bi	rthplace (State or Foreign
	Director	-	212-12-6186 AV	M 2□F 74	Yrs. Mont	ns Days	Hours Min.	(Month, Da April 2	1932 C	Maryland
	yland 30W		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Location	-11-2				10d. Inside City Limits
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	within 72 hours after death with the Maryland ane. then "netural", or items 23s or 28s-f show is Madical Exactive trust by notified at	Dire	10e. Street and Number 701 E. First			Zip Code			10g. Citizen of What C	Í
	ne 23	Funeral	11. Marital Status	SCIPET  12. Was Decedent Ever in U	J.S. 13. Was De	217	40 anic Origin? (Spe	ecify Yes or No	United	
9	after or iter	/ Fur	1 🔀 <b>N</b> ever Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2√2√No If Yes, Give	If Yes, s	pecify Cuban, I	Mexican, Puerto	Rican, etc.)	Black, Wh	ite, etc.
003	72 hours netural', lical Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			Specify:		Specify: W	hite
21215-0036	nin 72 n ne	plete	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed)	16a. Decedent's U (Give kind of life. DO NO	work done duri	n ing most of works	ng	16b. Kind of Business	s/Industry
	be filed within 72 ho ital Hygiene id other then "netur event, the Medical	Completed	Unknown	College (1-4or 5+)	Gen	eral E	mplove	p .	Wor	k Shop
and		Be	17. Father's Name (First, Middle, Last)  Benjamin	MaCaulan		18	. Mother's Tame	(First, Middle,	Maiden Surname)	
Maryland	2 should be and Menta ie marked aumatic ex	မ	19a. Informant's Name/Relationship (Ty	_	19b. Mailing Addr	ess (Street and			Peltzer er, City or Town, State,	Zin Codo)
	25 mg		Angie Mongan (	aretaker	701 Eas				agerstown	
Baltimore,	0 0		20a. Method of Disposition  XIXBurial 2 ☐ Cremation 3 ☐ R		Place of Disposition (f	lame of		ate	20c. Location - City of	
Itim	permit. Pag Department mportant: I any Injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	P.	leasant (	Grove	Cem. Ja	an 8,	2007 Reis	sterstown
Ва	Dep impo		1 1 my 16 1	Alle	Bur	and Address o	teen Fun	eral Ho	me & Crema	tory, PA
			27. Pa il. Enter the disease, or compli shick, or heart failure. List only or	cations that caused the deat e cause on each line.	th. Do not enter the m	ode of dying, s	UCh as cardiac o	rty Roa r respiratory ar	d Winfield	MD 21784 Approximate Interval Between
	Pilysician	1	Imm ate Cause (Final disease or condition resuling in death)	Cerebro	vascul	n a	end	ent-		Onset and Death
1	/Medical Examiner	1		Due to (or as a conseq	quence of):					7
		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence of):					
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68760,	death certificate be exe e attending physicien a ed for use as the burial-I	al Ex		Due to (or as a conseq	(uence of):					
89	tificate ng phy as the	Physiclan/Medical								
Вох	ath cer ttendir or use	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		pregnancy			23d. Date of de	•
	00	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	leath 5 ☐ Other (	specify)			Month	Day Year
ď.		y P	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	cause given ir	Part I.	23e. Did to	bacco use contribute to	the cause of death?
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3ec	has be	nple						24a. Was a		utopsy findings available completion of cause of
			25.144					perfor 1 ☐ Yes	med? death? 20No 1 ☐ Yes	11
5	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	ER/Outpatient 3 1	10.	Place of Death		7.77	
<u> </u>	ng Phys fter this neral di		27. Magner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injury at Work?			ence 6 Other (Spe	city)
Division of	Attending r death. ector: After by the fune	catle	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		М	1 🗌 Yes	2 🗆 No			
DΪΧ	after d Direc	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory)	ory, office	2	8f. Location (S City or Tow	treet and Number or Run, State)	ural Route Number,
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the cumpletely filled in by the funeral		29a. Certifier 1 Certifyin Phys	cian: To the best of my kno	wledge, death occurre	d at the time, d	fate and place, a	nd dus to the e	ausu(s) and marmer as	stated.
	To the P within 24 To the F c mplete	Medical	one)  29b. Signature and title of certifier	er: On the basis of examina and manner stated.						
	F3F8		DI Wall Co.	grucer	,   2	9c. License nui	8365	2	29d. Date signed (Mont) $1 - 4 - 07$	*
	HO		30. Name and address of person who con	npleted cause of death terr	1 23a) (Type, Print)				1-1-01	•
	7		AND AN J.	11AP1 368	ture	ved-1	lagere	town 1	MD 2176	10
4	Star Registra		31. Date filed (Month, Day, Year)  JAN 1 0 200	32 registrar's Signa	ture	,	U			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year January T, 20 ... Mills Metz . Facility Name (If not institution, give street and number) 4b City Town or Location of Death medi Cente nissula If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 1 F Days Hours **9**0 220-12-1246 10/24/1916 Ohio Usual Residence of Decedent 10b County 10c. City, Town or Location 10a State 10d. Inside City Limits 1 ☐ Yes 2 X No Wicomico Maryland Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3530 Meadowbridge Road 21822 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Webster B. Metz Elizabeth Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon Mills/son 3548 Meadowbridge Rd., Eden, MD 21822 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 1/8/06 Salisbury, MD 21. Signature of Funeral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (of as a consequence of) 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2.0No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 EN/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

**Physician** /Medical Examiner The law requires thet the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Івете 23в death

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item 27

Department of H Important: If its any injury or ot once.

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the Medical Examiner must be notified at

Director

Funeral

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Peges 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Hospitel or Attending Physician:

attending physicien and for use as the burial-transit signed by the a d be detached for should t rector, page 2 s director, his After thi death. Director: n 24 hours after d ne Funerei Direct bletely filled in by

Examiner Physician/Medical <u>م</u> Be Completed Certification; To

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

27. Manner of Preath Natural 2 Accident

5 Pending investigation 6 Could not be determined 3 Suicide 4 | Homicide

28b. Time of

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menning stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address Raffetto Joseph

who completed cause of death (Item 23a) (Type, Print) 400 E. Share

32 Registrar's Signature

State Registrar

Medical

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 5, 2007 JANUARY 6:20 A.M GLENDA JEAN NIKIRK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death THIRD STREET 515 E. CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
APRIL 27,1920

8. Birthplace (State or Forei Country)
WEST VIRGINIA **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 ☐ M 200 F 214-07-0131 86 Yrs Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 27 is marked other then "netural", or items 23a or 28a-f sho traumatic event, the Madical Examinar is ust be nutified at Completed by Funeral Director ALLEGANY CUMBERLAND 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 E. THIRD STREET 21502 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours atternent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "netural", or Ite Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOYAL BOGGS NAOMI STALLINGS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26537 JOSEPH NIKIRK SON 212 SEEMONT DRIVE, KINGWOOD, WV other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6 1 X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or once. HILLCREST MEML. PARK 01/08/2007 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio UPCHURCH FUNERAL HOME, 202 GREENE ST., CUMBERLAND, 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5ARS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physicien for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 mor 4☐Pregnant at time of death Month Day Year ed by the a 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 @onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No 1 ☐ Yes tuneral director 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) Certification: To 1 Inpatient Pis 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical d title of certifier 29b ignature a 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds 31. Date filed (Month, Day, Year) JAN 0 9 2007 State Registrar

DHMH 17 Rev 1/2001

Amended #19b, nls, 01/16/07, Allegany Co

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	10,07, A		1 = For State Registrar	State of	Marylar		artment of F <i>tificate of</i>		nd Mental Hy	/giene Reg. No	0.7	015	3
	Physici		Decedent's Name (First, Middle, Last BEAT)	*		NELS	ON		2. Date of D Month 01	Day	Year 2007	3. Time of 1720	f Death M
	/Medi Examir		4a. Facility Name (If not institution, give		•		4b. City, Town, o		Death	4c. County			
a se he	Funeral Director	7	5. Social Security Number 6. S 218–01–1287	ex □M 2 <b>X</b> F	7. Age ( <i>In yrs</i> . <b>92</b>	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of B (Month, D	ay, Year)	Cour	place (State of htry) YLAND	or Foreign
	Maryland Fr show fled at	tor	Usual Residence of Decedent  10a. State 10b. County  WV MINER	AL		ty, Town or Lo					1	0d. Inside Ci 1 □Yes	
	with the 3a or 28a tt be noti	I Director	10e. Street and Number  ROUTE 2, BOX 37	1			10f. Zip Code 26719			10g. Citizen of		ntry?	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. tem 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed For 1 Tes If Yes, Give Year or Da	ces? 2. Ma∑No e			lispanic Origin an, Mexican, P Specify:	? (Specify Yes or Nouerto Rican, etc.)	o- 14. Rac	ce - Americ ck, White,		
21215-0036	within 72 hou iene. than "natura the Medical E	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		4or 5+)	(Give life. L	lent's Usual Occup kind of work done OO NOT use retired MEMAKER	durina most of	f working	16b. Kind of B	usiness/In		
Maryland 2	ild be filed lental Hygi <b>ked other</b> ic event, t	To Be C	17. Father's Name (First, Middle, Last) PIERRE G. BURT			1101			Name (First, Middle	, Maiden Surnar			
	and 2 shou ealth and N n 27 Is mar ier traumat		19a. Informant's Name/Relationship (		HTER	19b. Mailin	g Address (Street BO JTE 2, -B	and Number o	or Rural Route Number	ber, City or Town,	State, Zip		
altimore,	0 0 <del>-</del> -		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification of the control		tate (	cemetery, cren	sition (Name of natory or other place		Date /12/2007	20c. Location DET	City or To		
Balti	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Lio	,	(0,)		Name and Addre	ss of Facility FUNER	AL HOME, EET, CUME	P.A.		21502	
8760,	Physician // Medical Examiner physician and physician and street is the paral-transit	dical Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last	Due to (c	used the deat ch line.  or as a construction as a consequence as a consequ	D(Ali)  Juence of):	er the mode of dyin		rdiac or respiratory			Approximate Interval Betto Onset and I	Death
O. Box 6	death certif s attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		rth 2 ☐ Feta int at time of d	aldeath 3□	Ectopic pregnancy Other (specify)				te of delive	,	Year
rds, P.	quires that the de n signed by the a and be detached f	by	Part II. Other significant conditions o	ontributing to dea	ath but not res	ulting in the un	derlying cause giv	en in Part I.		tobacco use cont Yes 2 □ No			
Vital Records,	sIcian: The law requires that the certificate has been signed by the rector, page 2 should be detache	Completed							24a. Was auto perf 1 Yes	psy ormed?	prior to cor death?	psy findings an pletion of ca	available ause of
	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 7	patient 2	ER/Outpatient	3 DOA Oth	or.	Death (Check only ng Home 5 ☐ Res		or /Cmaaih	4)	
ion or	ding Afte fune		27. Manner of Death 1	28a. Date of		28b. Time of Injury	28c. Injur Worl			how injury occur		//	
DIVISION	tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place o	of injury - At ho g, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location City or To	Street and Numb wn, State)	er or Rura	l Route Num	ber,
	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by	Medical (	29a. Certifier (Check only one)	vsician: To the basiner: On the basiner	sis of examina	owledge, death ation and/or inv	occurred at the tir restigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time	cause(s) and ma , date and place,	anner as st and due to	ated. the cause(s	
	To the within To the comp	M	29b. Signature and title of certifier				29c. Licenso		9	29d. Date signe			07
•	nho		30. Name and address of person who of the Vi Krama C	completed cause	of death (iten	n 23a) (Type, F	Print)	) Day	e Cumb	pole .	1. M.	7 719	T 2
	Sta Registr		31. Date filed (Month Pry Year) 20		gistrar's Signa	ature	2000	- Di.A	- Conv	- IUNC	_[ ]***		200

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of I	Maryland /		artment of H rtificate of L		nd Menta		ene . No.2 0 0	7 01	812
ı	Physic		Decedent's Name (First, Middle, William	Reese	0	wens	3		Me	ite of Death onth nuary	Day 200	Year	of Death
	/Medi Examir		4a. Facility Name (If not institution, g 4396 Tyaskin Ro		er)		4b. City, Town, or Tyaskin	Location of		luar y	4c. County o		
L	Funeral Director		5. Social Security Number 6 212-90-7025  Usuat Residence of Decedent	Sex 7. 1 <b>½</b> M 2□ F	Age (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Da Min. 3/2	te of Birth onth, Day, Y 20/197	<sup>(ear)</sup>	9. Birthplace (State Country) Marylan	or Foreign ad
	he Maryland 8a-f ehow offilied at	Director	10a. State 10b. County  Maryland Wicom	ico	10c. City, To	skir						10d. Inside	City Limits
	h with th	ai Dire	10e. Street and Number 4396 Tyaskin R	oad			10f. Zip Code 2186	55		10g	USA USA	at Country?	
9036	be filed within 72 hours after death with the Maryland stal Hyglene.  ed other than "naturel", or items 23e or 28e-f ehow event, the Medical Examinat must be notified at	d by Funeral	11. Marital Status 1 2 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	s? <b>S</b> iNo		Was Decedent of Hi tf Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origir n, Mexican, f Specify:	n? (Specify Yo Puerto Rican,	es or No- etc.)		American Indian, White, etc. white	
Maryland 21215-0036	e filed within 72 h at Hygiene. I other than "natu vent, the Madical	Completed	15. Decedent's (Specify only highest (Specif			(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired,	lurina most o	of working	16	b. Kind of Bus	ness/Industry	
yland	B a b	To Be C	17. Father's Name (First, Middle, La Herman Owens		'			Bren	nda Llo	oyd	iden Sumame,		
	d 2 s h ar 7 is treu		19a. Informant's Name/Relationship Brenda Fields/m		19	9b. Mailir 171	ng Address <i>(Street a</i> .4 Crestwo	nd Number o	or Rumal Route Ccle, S	e Number, C Balisb	ity or Town, S. ury, MI	ate, Zip Code) 21804	
Baltimore,	5 to		20a. Method of Disposition  1 M Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		te ceme	tery, crer	osition (Name of matory or other place Cemetery	1	Date /6/07		c. Location - C Salisbu	ity or Town, State	
Balt	permit. Page Department Important: If eny injury or		21. Signature of Funeral Service Lic	there	(FSP		Holloways 501 Snow					l Associ 21804	ation
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Squantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	iline.	sphi ooi):	ier the mode of dying in the m			ratory arrest		Approxim Interval B Onset and	etween
x 68760,	death certificate be executed e attending physician and of for use as the burial-transit	ilcal	that initiated events resulting in death) Last	d.  23c. If yes, outcom	as a consequence	e of):					1		
P.O. Box	if the death certifii by the attending pached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth	2 Fetal dear at time of death		Ectopic pregnancy Other (specify)				23d. Date Month		Year
	w requires that the been signed by the should be detache	٥	Part II. Other significant conditions	contributing to death	but not resulting	in the ur	nderlying cause give	n in Part t.	23	e. Did tobac	/	ute to the cause of	
	The law ate has b page 2 sl	Completed							-	a. Was an autopsy performed Yes 2	1? pric	re autopsy finding of to completion of oth? Yes 2 \( \square\) No	s available cause of
f Vit	nyelcia nis certi directo	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	tient 2 ER/C	Outpatien	t 3 DOA Other		Death Chec	200	e 6 Other	(Specify)	
o uc	ding Pl h. After tl funera		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of In (Month, D	Day Year)	Time of Injury	Work'		28d. De	scribe how i	ntury occurred		
Divisi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	2 Acordent investigate 3 Suicide 6 Could not 4 Homicide determine	be 28e. Ptace of I	ntury - At home, etc. (Specify)		eet, factory, office	es 2 @NO	28f. Loc City	y or Town, S	t and Number tate)	or Rural Route Nu	
_	Hospita 4 hours Funeral	Medical C	CHOCK ONLY SHEWINGUICEI EX	hysician: To the besiminer: On the basis	st of my knowledg	e, death	o occurred at the time	e, date and p	place, and due	to the caus	e(s) and mann	er as stated	
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	and manner:	stated.		29c. License  Print)  \$\frac{1}{5} \tag{4}	number		29d.	Date signed (	Month, Day, Year)	
	512	1	30. Name and address of per	completed cause of	death (Item 23a)	) (Type, I	Print)	5,1	K bu	1440	21801		
	Sta Registr		31. Date filed (Month, Day, Year) 9	2007 32. Segis	strar's Signature	M	erle	JEN Y	13 004	VVV	U. TER		

07-00529 Jimmy Lee Poland

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State	Ce.	rtificate c			Reg. I	No. 200	7 0 1 2 !		
Physician Medical Examine	7	i. Decedent's Name (First, Middle,Last) Jimmy	Lee	Р	oland		Date of Death Month Da January 19, 2	ay Year 2007	3. Time of Death 1530 hrs		
		4a. Facility Name (if not institution, give 153 Greene Street	street and number)		4b. City, Town, or Loc Frostburg			4c. County of Deat	h		
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yr	If Under 1 Year  Months Days	If Under 24Hrs Hours Min	8. Date of Birth (N	MM/DD/YYYY) 9 Bi	rthplace (State or gn Maryland puntry)		
any	-	Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Loca	ition				10d. Inside City Limits		
Maryland 28a-f show any 1 at once.		MD Allegan	у	F	rostburg				1 X Yes 2 No		
n the Maryland 3a or 28a-f sh otified at once	2	10e. Street and Number 153 Greene S	Street		10f. Zip Code 2153	32	10g.	Citizen of What Cou USA	untry?		
Baltimore, MD 21215-0036  Permi Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If them 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Laneral	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	1f	as Decedent of Hispar Yes, specify Cuban, M	exican, Puerto Ri		14. Race - Ame White, etc.	rican Indian, Black,		
urs after tural",	⋧┞	3 Widowed 4 Divorced  15. Decedent's Education (Specify onl	f Yes, Give Year or Dates: y highest grade completed)	16a. Decede	Yes 2 X No s	(Give kind of wor		Specify: bb. Kind of Business	White /Industry		
36 n 72 hoi nan "na lical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		nost of working life, DC aborer	O NOT use retired	d)	Construc	tion		
5-00; ed with tygiene other ti	5	17. Father's Name (First, Middle, Last)			18.1	Mother's Name (F	First, Middle, Maio		.01011		
ould be filed within 7 defined by Mental Hygiene.  S marked other than fice event, the Medical		James 19a Informant's Name/Relationship (Ty	Lee	Polan	d (Street ar	Joan	ral Route Number	Har	_		
MD 2 d 2 shou lith and lith n 27 is r		Joan Jenkins / mo	ther	87	Victoria L	ane, Fro	ostburg,	MD 2153	2		
Baltimore, MD permi Pages I and 2 sho Department of Health and Infortant: If item 77 is injury or other traumati		20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from State	crematory or c				Oc. Location - City o			
Baltimo Department Important: Injury or ot	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens		ımberla 22.	nd Cremato Name and Address of	ry 01/21 Facility Adam	1/2007   ns Famil	Cumberla v Funeral	nd, MD Home, P.A.		
	Fabert C. Colonic 404 Decatur Street, Cumberland, MD 2										
Physician /Medical		failure. List only one cause on eac			the filode of dying, suc	or as cardiac or re	espiratory arrest,	snock, or neart	Approximate Interval Between Onset and Death		
Examiner		or condition resulting in death)	ue to (or as a consequence o								
		Sequentially list conditions, building if any, leading to immediate Discusse Enter Underlying Cause	ue to (or as a consequence c	of):							
hed ted missit	Exam	events resulting in death) Last	ue to (or as a consequence o	of):					1.1		
execu an and al - tra	Medical	X UNPENDED	AMENDED #23a.PII	.27.perM	E, g863, 1/31	/07 TT	· <u>-</u>				
76 icat		F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome of preg	nancy		Ectopic pregnanc		23d Date of deliver	y Day Year		
Box 687 e death certifi the attending ed for use as t	Pnysician	past 12 months?  1 Yes 2 No 9 Unknown	Pregnant at time of de	a dla	other (Specify)						
, P.O. Bc fres that the dea signed by the a be detached for		Part II. Other significant conditions		esulting in the	underlying cause give	n in Part I	23e Did tobac	cco use contribute to	the cause of death?		
ds, P.O. equires that the sen signed by uld be detach	Completed by	Hypertensive cardi	ovascular diseas	e			1 Yes 2		bably 4 V Unknown utopsy findings available		
SCOFC ie law re ie has be ge 2 sho							autopsy performe	prior to death?	completion of cause of		
ian: The sertifical sector, pa	2  -	25. Was case referred to medical examiner?				Death (Check on	L-1	No 1 ✓ Y	es 2 No		
n of Vital Records.  Jing Physician: The law requir.  After this certificate has been funeral director, page 2 should	2  -	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of		ner <sub>4</sub> Nursing I	Home 5 Res	injury occurred	er: Scene		
ttending death. tor: At the fun	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I    A										
Division ospital or Attent hours after death nneral Director: y filled in by the		3 Suicide 6 Could not b determined	28e Place of Injury . At h	ome, farm, str	eet, factory, office build	ding, etc. 28	Bf. Location (Stree or Town, State		ural Route Number, City		
bou by	<u>.</u>	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	n: To the best of my knowled On the basis of examination a and manner stated								
F * F 8	ME	29b. Signature and title of certifier	1		29c. License no			9d. Date signed (Mo			
	-	30. Name and address of person who co	beef Mo		O.C.IVI.I		J	anuary 20, 200	1		
P	ं	Tasha Greenberg MD. A	ssistant Medical Exam	niner 111	Penn Street, Ba	Iltimore, MD 2	21201				
Star Registra	_	31. Date filed (Month, Day Year) JAN 2 4 200	32 Registrar's Signat	e God	Alffred P	_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** arker lan 3 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Medica Arundel polis Avunde If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 M 2 □ F Months Days Hours Director Marylana Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 1 💢 es 2 🗆 No Director 00/15 Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★es 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after c Health and Mental Hygiene. em 27 is marked other than "natural", or iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify. Specify: Year or Dates: 44-46 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( ဥ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21403 nmas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 3 ☐Removal from State 1⊠Burial 2 □ Cremation 4 ☐ Donation, 5 Other (Specify) 21. Signatura of Furieval Service Licerise Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Car dio my **Physician** Chemi ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform To the Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HealBech, 540 114/07 D46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month)

Day, Year)

Milch

2001

gistrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2007 Philbin 4, 5:30A. Ada Marie January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Hospital Gaithersburg
If Under 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗗 F 87 Director 577-36-4947 Feb. 20, 1919 Washington, D.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director Md. Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the M-dical Examiner must be 13900 Congress Drive 20853 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Completed by 3 Midowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H Item 27 is marked oth other traumatic even Be Mark Sherier Vaughan Nell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13900 Congress Drive Rockville, Maryland 20853 Michael J. Philbin/ Son Department of Health Important: If Item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Jan. 11, 1 Burial 2 □ Cremation 3 □ Removal from State Arlington Nat'l Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Arlington, Virginia 21. Signature of Fyneral Service Linns 22. Name and Address of Facility DeVol Funeral Home 2222 Wisc. Ave., N.W. Washington, D.C. 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia 4 days /Medical Due to (or as a consequence of): Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Alzheimer's Dementia, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performe 1∐ Yes 2**k** No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D053654

Registrar
DHMH 17 Rev 1/2001

State

Maryland 21215-0036

fimore,

P.O. Box 68760,

Division or Vital Records,

9901 Medical Cester Drive, Nochwille, mo 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 0 9 2007

VINS OAK OAK

Registrar's Signature

			1 - For State Registrar	State of Ma	aryland	•	artmen tificat			nd M		giene Reg. No:	07	01816
F	Physicia	an	Decedent's Name (First, Middle, La		ъ.						Date of De. Month	Day	Year	3. Time of Death 8:00 A <sub>M</sub>
	/Medic	al	Carlos  4a. Facility Name (If not institution, given	Padill	.a-K1	os	4h City	Town or	Location of	Death	JANUARY	4, 20	07 unty of Deatl	
	Examin	er	10126 RIGGS ROAD	e street and number,			4D. Oity,		LPHI	Death			NCE GEO	
E	uneral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. I	ast birthday)		If Under 1 Year   If Under 24 Hrs.				th	nplace (State or Foreign	
	rector		581-68-8141	ÄM 2□F	88	Yrs.	Months	Days	Hours	Min.	(Month, Da DECEMBER			intry) ERTO RICO
p			Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Location									10d. Inside City Limits
aryla	o ho	5	,		TOC. City			-						1 ☐ Yes 2 ☒ No
M edi	28a-1	Director	MARYLAND PRINCE  10e. Street and Number	GEORGE 'S			ADELPH 10f. Zip					10a Citizer	n of What Co	untay?
with	Sa or						101. 2.10		783				U.S.A	•
death	ms 23	Funeral	10126 RIGGS ROAD	12. Was Decedent 8	ver in U.	S. 13. )	Vas Deced			in? (Spe	cify Yes or No Rican, etc.)	- 14.	Race - Ame	rican Indian,
after		Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces?	lo				n, Mexican, <i>Specify:</i> P				Black, White	etc.
3 ones	od other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:W	W_II		125 165	2 140	Зреспу. 1	OLICE	RIGHN	Sp	ecify:	WHITE
72 h	nati	Completed	15. Decedent's E (Specify only highest gr	ducation ade <i>completed)</i>		16a. Deced	dent's Usua kind of wo	il Occupa rk done d	ition fu <i>ring most o</i> )	of working	g	16b. Kind	of Business/	ndustry
Withir	than the Me	mp	Elementary/Secondary (0-12)	College (1-4or 5	+)		MACHIN		,			ртр	E FACTO	RY
filed Hygi	ont,	Ö	17. Father's Name (First, Middle, Last	)			LIGHT		18. Mother	's Name	(First, Middle,			
d pelle pe	ked c	ToB	SEVERO PADILLA							DOLOR	RES RIOS			
Ital yially 2.12.13-0050 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	s mar	-	19a. Informant's Name/Relationship	Туре, Print)		19b. Mailir	ng Address	(Street a	nd Number	or Rurai	Route Number	er, City or To	own, State, 2	iip Code)
and 2	n 27 i		MIGDALIA PADILLA -	DAUGHTER					D, ADEL	PHI,	MARYLANI	20783		
S S S	if iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [	Removal from State	20b. PI	lace of Dispo emetery, cren	sition (Nar natory or o	ne of ther place	e)	Di	ate	20c. Locat	tion - City or	Fown, State
Pages tment of	tant:		4 ☐Donation 5 ☐ Other (Special	(y)	CEME	ENTERIO				_/13/2	2007	PUERTO	RICO	
Depar	important: If Item 27 is marked any injury or other traumatic e once.		21. Signature of Funeral Service Line	X )	16	H	INES-R	INALD		RAL HO	OME, INC.			
			23a. Part1. Enter the disease, or con	plications that caused	the death								ING, MA	RYLAND 20904 Approximate
. Pro-			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	10.			,						Interval Between Onset and Death
	siciān edical		disease or condition resulting in death)	aCEREBE		ULAR AC	CIDENT							
Exa	miner													
70	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequ	uence of):								
ecute	trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c										
OI VILGI INCOLUS, F.C. DOX 00 000, Physician: The law requires that the death certificate be executed	hysician and the burial-transit	E	Togothing in doaling cast	Due to (or as	a consequ	Jence ot):								
cate	physi s the t	edicai	•	d										
certif	nding use a:	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					-			23d	I. Date of deli	very
de all	d for I	Physician/M	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			]Ectopic pr ] Other (sp						Month	Day Year
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es tha	been signed by the ettending p should be detached for use as	by F	Part II. Other significant conditions	contributing to death bu	ut not resu	ulting in the u	nderlying o	ause give	n in Part I.					the cause of death?
inbe.	pino	ted									10	Yes 2 KJ N	4o 3∐Pr	obably 4 DUnknown
<u>a</u>	5 CA	Completed							• • •		24a. Was autor	osy	prior to d	topsy findings available ompletion of cause of
E T	cate , peg										1 Yes	rmed? 2⊠ No	death? 1 ☐ Yes	2□ No
VIII	rector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		5D/0 : "		Othe			(Check only o		7	
5 £	After this certificate ha funeral director, pege	-	27. Manner of Death	28a. Date of Injur (Month, Da)		ER/Outpatier 28b. Time of		8c. Injury Work	at Nurs		ne 5 Aesi 8d. Describe			ify)
g gg g	r: Afte	atioi	1 Natural 5 Pending 2 Accident investigation		/ Year)	Injury	М		(? ∕es 2.∐N	lo				
Atte	by th	Certification:	3 Suicide 6 Could not t 4 Homicide determined		ry - At ho	me, farm, str	eet, factor	, office		2	8f. Location (	Street and N	lumber or Ru	ral Route Number,
is effect	led in	Cer			. (=,-=,	<u></u>								
the Hospital or Attending	Fune tely fil	ical	(Check only 2 Medical Exa	nysician: To the best ominer: On the basis of	examinat	wiedge, deatl tion and/or in	n occurred vestigation	at the tim , in my op	e, date and pinion, death	l place, a h occurre	nd due to the dat the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
o the	To the Funerel Director: A completely filled in by the fu	Medical	29b. Signature and title of certifier	and manner sta	ILOG.		290	. License	number			29d. Date s	igned (Monti	n, Day, Year)
o i	£ 8		Myardoa	a MD				D166					8, 200	
4			30. Name and address of person who	completed cause of de	eath (Item	23a) (Type,	Print)						-,	
			C. VERGARA - SOARE	S, M.D., 9940	) FRAN	KLIN SQ	UARE D	RIVE,	BALTIM	MORE,	MARYLANI	21236		
	Sta		31. Date filed (Month, Day, Year)	2007 32. Redistra	ar's Signat	ture	-						-	
	Registr	ar	UAII U U	LUUI MAN	Red .	RI. RA	284	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AND TEMP 24a Por VERB 6863 1/24/07 US

	•	Stata Registrar		epailment of Health and Certificate of Death	Reg	3. No 2 0 0 7	0   8					
Physicia /Medic		Decedent's Name (First, Middle, Last)     Dorothy Ma	e Rosenberry		2. Date of Death January		3. Time of Death 3:30 PM					
Examin		4a. Facility Name (If not institution, give s Northampton Manor		4b. City, Town, or Location of De Frederick	eath	4c. County of Death Frederic	k					
Funeral Director		TIP TO BETT	M 2NF 7. Age (In yrs. last birtho	Months Days Hours M	in. July 14,	9. Birthpl 1922 Mary	ace (State or Foreig Land					
Maryland	tor	Usual Residence of Decedent  10a. State  Maryland  Trederich	t 10c. City, Town of Frede:			10	0d. Inside City Limit					
h with the	al Director	10e. Street and Number 750 Carroll Park	cway, Apt. 6D	10f. Zip Code 21701		g. Citizen of What Coun	try?					
within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f ehow in Madical Examiner must be motified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 WWidowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1  Yes XX No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 □ Yes ※ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e Specify: Whi	etc.					
s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exeminer maint by nutitled at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1,4or 5+)	acedent's Usual Occupation live kind of work done during most of v e. DO NOT use retired) ales/Clerk	vorking	16b. Kind of Business/Industry  Drug Store						
2 should be filled and Mental Hygis is marked other aumatic event,	To Be C	17. Father's Name <i>(First, Middle, Last)</i> <b>Charles</b> E. S	Shepley		lame (First, Middle, Ma Sliker	ilden Sumame)						
1 and 2 sho Health and Iem 27 is ma		19a. Informant's Name/Relationship <i>(Typ</i> Mrs. Temple M. Abre	echt, daughter 8			, , , , , , , , , , , , , , , , , , , ,	/					
Page nent o ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	cemetery.	sposition (Name of crematory or other place) ng Crematory Jan. 17,		Smithsburg						
permit. Page Department o Important: If eny Injury or once.		21. Signature of Funeral Service License  23a. Part1. Enter the disease, or complice	MO0255	22. Name and Address of Facility Keeney and Basf 106 East Church	St. Freder	CICK, MD ZI	701					
	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
death certif e attending d for use as	⋛	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year						
es the	2	Part II. Other significant conditions cont	ributing to death but not resulting in th	e underlying cause given in Part I.		2 No 3 Proba	bly 4 Unknov					
	e Completed	25. Was case referred to medical		26 Place 4.0	autopsy performe  1 Yes 2	d? prior to com death?	sy findings availab pletion of cause o					
hys the sign	10 8	1 163 2 VNO	spital: 1   Inpatient 2   ER/Outpa	100		ce 6 Other (Specify)						
tending leath. tor: After the fune	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year) 28b. Tim Injur	e of 28c. Injury at Work?  M 1 \[ Yes 2 \] No	28d. Describe how	injury occurred						
		4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, S							
the Hospital hin 24 hours a the Funeral I mpletely filled	edical	29a. Certifier 1 Cartifying Physic (Circles only one) 2 Medical Example	cian: To the best of my knowledge, do it: On the basis of examination and/o and manner stated.	eath occurred at the time, date and pla r investigation, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as sta and place, and due to t	ted. he cause(s)					
To the To the complet	2	29b. Signature and the of certifier	Im mod	29c. License number D 58391.		Date signed (Month, D January 17,						
10	- 1	30. Name and address of person who	, 801 Toll House									

State Registrar JUSTIN

31. Date filed (Month, Day, Year)

nas

DHMH 17 Rev 1/2001

MO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOCKMAN

JAN 1 2 2007

RES-000

NORTH WOLFE STREET BALTIMORE, MARYLAND

JANUARY 10, 2007

Registrate   Security   Securit	1 _ For	State of Maryland	Department of I	Health and I	Mental Hygie	ene	01010					
DNALP    County   Cou	1. Decedent's Name (First, Middle, Last)				2. Date of Death	time Sar Sar I	3. Time of Death					
To State and Number   100. County   100. City   100 Cit	The Linus Hope start of the second of the se	T. Ago (In yrs. last	4b. City, Town, Back T.  Birthday) If Under 1 Year Months Days	or Location of Death	S. Date of Birth (Month, Day, Y	4c. County of Deal	thplace (State or Foreign					
4   Donation   Signature of lygoral Survey Lengths		10c. City, To	own or Location			10d. Inside City Limits 1 ☐ Yes 2√√No						
A   Donation   Signature of lyugars Saryous Lengages   Part   Enter the disease, or complications that caused the death. Do notwer the monotonic program   Part   Enter the disease, or complications that caused the death. Do notwer the monotonic program   Part   Enter the disease, or complications that caused the death. Do notwer the monotonic program   Part   Enter the disease, or complications that caused the death. Do notwer the monotonic program   Part   Enter the disease, or complications that caused the death. Do notwer the monotonic program   Part	M Montgamery  10e. Street and Number	Kensing	10f. Zip Code									
A Donation 5   Other (Specify)   S. Carroll Crematory 16/007   Initial No.	2926 Faulkner Place 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 2 2 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2	13. Was Decedent of II Yes, specify Cub			lo- Black, White, etc.						
Constitution   Complete   Concept   Content   Concept   Content   Concept   Content   Concept   Content	15. Decedent's Educ (Specify only highest grade	completed)	(Give king of work done	aurina most of woi	rking	b. Kind of Business	/industry					
A   Donation   S   Other (Speechy)   S. Carroll   Cerematory   Factor   Cerematory   Factor   Cerematory   Factor   Cerematory   Factor   Facility   Factor   Fa	17. Father's Name (First, Middle, Last)		ostal Employee		me (First, Middle, Ma		ment					
20b. Place of Disposition (Name of Jacobs Control of State Control of State Control of State Control of Control of State Control of Control of State Control of Contr	p Donald E. Reed, Sr.	e, Print) 1	9b. Mailing Address (Stree	J		City or Town, State,	Zip Code)					
23a. Part I. Enter the disease, or complications that caused the death. Do not where the mode of the standard little and little. List only one cause on each line. Interest Between diseases of complete and action or cause in each line.    Immediate Cause (find cause)   Immediate Cause)   Immediate Cause (find cause)   Immediate Cause)   Immediate Cause (find cause)   Immediate Cause)   Immediate Cause)   Immediate Cause (find cause)   Immediate Cause)   Immediate Cause (find cause)   Immediate Cause)   Imme	20a. Method of Disposition  1  Burial 2  Cremation 3  Re 4  Donation 5  Other (Specify)	moval from State S. Carc	roll Crematory or other pla roll Crematory  22. Name and Addr	1/6/200 ass of Facility	)7 Wir	field, MD	Town, State					
Sequentially list conditions   Sequentially list conditions	23a, Part1. Enter the disease, or complic	ations that caused the death. D					Approximate					
24a. Was an autopsy performed? 1   Yes   2   No   3   Probably   4   Wonknown  24a. Was an autopsy performed? 1   Yes   2   No   1   Yes   2   No    25. Was case referred to medical examiner? 1   Yes   2   No   Hospital: 1   Impatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)  27. Manny of Death   1   Yes   2   No    28a. Date of Injury   28b. Time of Injury   At home, farm, street, lactory, office   28l. Location (Street and Number or Rural Route Number, City or Town, State)  28b. Place of Injury - At home, farm, street, lactory, office   28l. Location (Street and Number or Rural Route Number, City or Town, State)  29c. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Dey, Year)   TANNARY 5, 2007   TAN	disease or condition resulting in death)  Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
24a. Was an autopsy performed?   24a. Was an autopsy performed?   1   Yes 2   No   1   Yes	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 Live birth 2 Fetal dea 4 Pregnant at time of death	ath 3 ☐Ectopic pregnand	у								
25. Was case referred to medical examiner?  1   Yes   2   No		ributing to death but not resultin	g in the underlying cause g	ven in Part I.	1 ☐ Yes 24a. Was an autopsy performe	2 No 3 Pi	robably 4 Winknown utopsy lindings available completion of cause of					
27. Mann of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 2 No 28d. Describe how injury occurred 28d. Describe how injury occurre	25. Was case referred to medical examiner?	ospital:	Out-101	hor	16.0	0 00000						
29a. Certifier (Check only one)  29b. Signature and title of certifier  WWWS MEDICAL DOCADY  30. Na e and address of person who completed cause of death (Item 23a) (Type, Print)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  JANUARY 5, 2007  BINTIMORE MID 21281		28a. Date of Injury 28t (Month, Day Yeer)	b. Time of Injury M	ary at ork?  ] Yes 2 □ No	28d. Describe how	injury occurred						
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  7ANUMY 5, 2007  30. Nalle and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Dey, Year)  7ANUMY 5, 2007  BHT WYKE WD 21281		building, etc. (Specify)	dge, death occurred at the t	ime, date and place	City or Town,	State) se(s) and manner as	s stated.					
January 5, 2007  30. Na e and address of person who completed cause of death (Item 23a) (Type, Print)  BATT MOVIE, MD 21281		er: On the basis of examination	and/or investigation, in my	opinion, death occu	urred at the time, date	and place, and due	o to the cause(s)					
30. Na e and address of person who completed cause of death (Item 23a) (Type, Print)  REUNN WOODS, THE JOHNS HOPILING HOSPITATIL, 600 NORTH WOLFE STREET.		S, MEDICAL DOC			JA	NUARRY 5,	2007					
				lit wolfe	STRUCT, BI	ht morne,	mD 21287					

DHMH 17 Rev 1/2001

			1 - For Amend Item 2	State of per	Marylan verb.	d / Depa <b>g866</b> (	odyże odyże rtificate	874 874	ealth a <b>hb</b> Death	and M	ental Hyg	jiene	007	0	820
			1. Decedent's Name (First, Middle, Last,						-		2. Date of Dea	ith			me of Death
	Physic /Medi		John Raymond Re	avis. S	r.						Month Januar	v 4.	2007		55 A <sup>M</sup>
	Exami		4a. Facility Name (If not institution, give	street and numi	ber)		4b. City,	Town, or	Location of	f Death		4c. County of Death			
			Anne Arundel Medi	cal Cen	ter		Anı	napo	lis				Anne A	runde	1
	Funeral		5. Social Security Number 6. Sec	x 7 M 2□F	. Age (In yrs. I		If Under Months		If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day 8/17/5	Year)	9. B	irthplace (S	tate or Foreign
	Director		220-34-7970 Usual Residence of Decedent	4	68	Yrs.					8/17/3	38	I	owa	
	land		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Ins	ide City Limits
	Mary	ō	Maryland Anne Ar	undol		1	Edgewa	ator						1[	Yes 2 No
	28a	rec	10e. Street and Number	didei			10f. Zip					l 0g. Citiz	en of What C	Country?	Λ
	h with	O IE	110 Valley View A	ve.				2103	7				USA		
	deat	Funeral Director		12. Was Deced Armed Ford	ent Ever in U.	S. 13. V	Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - Am	nerican Indi	an,
9	or its	F	1 Never Married 2X Married	1 X Yes 2	. □ No		1 ⊡ Yes 2		Specify:	, Puento i	rican, etc.)		Black, Wh	white	
8	nours	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dat	es: 1957-	62	103 2	22 140	эрвину.				Specify:	MIITLE	
21215-0036	be filed within 72 hours efter death with the Maryland hat Hygiene. at other then "naturel", or iteme 23e or 28e-f show event, the Medical Exertirat must be notified at	Completed by	15. Decedent's Edu (Specify only highest grade	cation e co <i>mpleted)</i>		16a. Deced	ient's Usua kind of wor DO NOT us	l Occupa k done d	ition uring most	of work!	ng	16b. Kin	d of Busines	s/industry	
12	withir ane. then	m d	Elementary/Secondary (0-12)	College (1-4	lor 5+)		e Pres						21		
d 2	Hygin Hygin		17. Father's Name (First, Middle, Last)			V TC6	e rres	staei		r's Name	(First, Middle,		Glass		
Baltimore, Maryland	m = 0 5	To Be	Frank Mars	hall Rea	avis.	Jr.					ry Gene		-	ond	
J.	Should Man	-	19a. Informant's Name/Relationship (Ty				ng Address	(Street a	nd Numbe		I Route Numbe				
ž	nd 2 alth a 27 is ir trau		Mary Janeen Reavi	s/ Wife		110 \	Valley	Vie	ew Av	e.,	Edgewat	er, l	MD 210	37	
re,	permit. Pages 1 and 2 should by Depertment of Health and Menta Important: if Item 27 is marked any injury or other traumatic sonce.		20a. Method of Disposition		l a	lace of Dispo	sition (Nam	e of	) i	D	ate	20c. Loc	ation - City o	r Town, Sta	ite
Ë	Page nent c int: if		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from St	ate   _	e of F				1/8/	07	Sil	ver Sp	ring.	MD.
att	permit. Depertuimporta		21. Signature of Funeral Second License	90		22	. Name and	d Address	s of Facility	Ge	orge P.				
Ω.	89558		I full the	gnature of Pinera S. & Licensee 22. Name and Address of Facility George P. Kalas Funera 2973 Solomons Island Rd., Edgewater, M.											
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence	(aux	er the mode	a or aying	, such as	cardiació	r respiratory arr	est,		Interva	ximate al Between and Conth
68760,	The law requires that the death certificate be executed site has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last		as a consequ	ence of):					_				
.O. Box	at the death certific by the ettending p tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal nt at time of de	death 3	Ectopic pre Other (spe					23	d. Date of de Month	elivery Day	Year
Records, P.	w requires that been signed should be det	þ	Part II. Other significant conditions con	ntributing to dea	th but not resu	Iting in the ur	nderlying ca	use give	n in Part I.		23e. Did to		e contribute t		e of death? 4 ∐Unknown
al Reco	: The law r cete hes be ; page 2 sh	Completed							-	_	24a. Was a autops perform	ned?	prior to death?	completion	ings available of cause of
Vital	Physicien: T rthis certificet ral director, pa	Be	25. Was case referred to medical examiner?	lospital: 🛌 🖊				Othe	-		Check only on				
ð	this aldi	၉	1 Yes 2 No	1 DRATE		ER/Outpatient 28b. Time of		-	4 🗀 Nui		ne 5 Reside			ecify)	
Ö		tion	1 Delatural 5 ☐ Pending	28a. Date of (Month,	Day Year)	Injury	M	Bc. Injury Work	es 2∐N		od. Describe no	w injury	occurred		
Division	Attendi er death. ector: A by the fu	fica	3 Suicide 6 Could not be	28e. Place of	f Injury - At hor	me. farm. stre			03 2 01		8f. Location (St	reet and	Number or F	ural Route	Number
ē	after de la Direct	Certification:	4 Homicide determined	building	, etc. (Specify	)	, , , ,	011100			City or Towi	, State)			rvanibor,
	To the Hospits! or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) 2 Medical Examin	sician: To the base and manne	is of examinati	vledge, death ion and/or inv	occurred a restigation,	it the time in my opi	e, date and inion, deat	place, a	nd due to the ca	ause(s) a ate and p	nd manner a lace, and du	s stated. e to the car	use(s)
	Withir To th	ž	29b. Signature and title of certifier	11	1		29c.	License	number /	· \	2	9d. Date	signed (Mon	th, Day, Ye	ar)
			( ) Netenbell	W SSW	(X)			DI	0 SK	7		(10)	412	v+	•
1	1/1		30. Name and address of person who are	SEM	death (Inch	NO.	Print)	2 1	Soad	30	DAN	(QP	His a	W2	461
	Sta Regist		31. Data filed (Month, Day, Year)  JAN 0 8	32. Reg	ristrar's Signati	ure	neck	,			,	1	V		

		-	For State Registrar	State of Maryland			of Health a of Death		F	Reg. No.	007	0   8	21
	Physici	an	Decedent's Name (First, Middle, Last     LARRY ROBER						l. Date of Dea Month JANUAI		5 2007	3. Time of 4:01	
The second	/Medio Examin	000	4a. Facility Name (If not institution, give Union Hospita	street and number)		4b. City, To	own, or Location of			4c. (	County of Death		u
	Funeral Director		217 74 4170	ex $3 \times 10^{-7}$ Age (In yrs. la $48$	ast birthday) Yrs.	If Under 1 Months	Year If Under Days Hours	Min	Date of Birth (Month, Day ept 2	v. Year) Country)			
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside Ci	ty Limits
	ath with the Marylan s 23s or 28s-f ehow	ctor	MD Cecil	El	kton							1 🗆 Yes	2 🔀 No
	vith the	Director	10e. Street and Number	D		10f. Zip C					en of What Co	untry?	
	leath v	Funerai	149 W. Thomson	12. Was Decedent Ever in U.S	6. 13. \		921 nt of Hispanic Ori	gin? (Speci	fv Yes or No-		4. Race - Ame	ncan Indian,	
920	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23e or 28e-f ehow event, the Medical Exartinal transitie rediffied at	by	1 □ Never Married 21 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1			nt of Hispanic Ori y Cuban, Mexicar No Specify:		can, etc.)		Black, White Specify: W	n etc. hite	
215-0036	n 72 ho "natur volical	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual kind of work DO NOT use	done during mos	t of working		16b. Kir Fik	od of Business/l	ndustry	
	d within piene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)			ssociat	:e			nufact	urer	
Maryland 21		To Be C	17. Father's Name (First, Middle, Last) Henry Reynold						First, Middle, Murso		Su <i>m</i> am <i>e)</i>		
Aar)	s 1 and 2 should f Health and Mer Item 27 Is marks other traumatic		19a. Informant's Name/Relationship (7				Street and Number						
	s 1 and if Health Item 27 other t		Cynthia P. Rey 20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name	Thomson	Dr.			MD . 2		
altimore,	0 0		1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Be	thel	Cemet	tery	1/18	/07	Ches	sapeak	e City	, MD
Balti	permit. Pag Department Important; I any injury o		21. Signature of Funeral Service Licen		10 Ga	Name and	Address of Facility Funera st Cros	l Ho	me of	Ste	ephen :	L. Sch	aech
	<u></u> ≠ ⊲		28a. Part1 Enter the disease, or company shock, or heart failure. List only Immediate Cause (Final	plications that caused the death.	. Do not ent	er the mode	of dying, such as	cardiac or i	respiratory ar	rest,		Approximate Interval Bets Onset and D	e ween
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ		10 CA10	DIAL	(N	fre	Ch	4,0		
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Ş,	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):								
o,	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	cDue to (or as a consequ	ence of):								
8760,	ate be hysicia the but	dicai	(	d									
Ö	eath certific attending pl	/Med	IF FEMALE:	23c. If yes, outcome of pregnar	ncv						3d. Date of deli		
P.O. Box	0 0	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pred Other (spec					Month	,	/ear
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Rec		Completed									prior to death?	topsy findings a completion of ca 2 □ No	ause of
/ital	cien: ertifica ector, p	Bec	25. Was case referred to medical examiner?				7	of Death (	Check only o				
of	Physi r this c rral dire	: To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	ER/Outpatien		Other: 4 Nuc. Injury at Work?		e 5 🛣 Resid		Other (Spec	city)	
on	utending F death. ctor; After y the funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐						
Division of Vital Records,	- 00	Certification:	3 Suicide 6 Could not b. 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,		eet, factory,	office	28	If. Location (5 City or Tow		l Number or Ru	ral Route Num	ber,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical (		ysician: To the best of my knowniner: On the basis of examination and manner stated.									)
	To the To the Comple	Me	29b. Signature and title of contifier			29c.	License number			29d. Date	signed (Month	n, Day, Year)	7
)			) NAME &	M)	920) 57	Brint	D > 64	11		JA	when	115,2	100/
	8		30. Name and address of pers who	Completed cause of death (Item	- ; (Type,	Print)	Ob Bo	w 57	REET	_	ELKN'	1) MD 9	21
September 1	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signat	urg. A	here							

			1 - For State Registrar		State of M	1arylan		artmen rtificat			and M		Reg	ene () (	7	0   822	2
	Physici	an	1. Decedent's Name (First,			D	dinger					2. Date Monti	١ , _	Day	Yeer	3. Time of Death	
1	/Medi	cal	Elmer  4a. Facility Name (If not ins		ISSEII		edinger		Town or	Location o	f Death	01.	- 15	4c. County	of Death	10:30P	M
1	Examir	ıer	417 Winmer	_	otroot ario nambo	/			nberla		Dogin			Allega			
	Funeral		5. Social Security Number	6. Se:		ge (In yrs.	last birthday)	If Unde	r 1 Year Days						9. Birthp	ace (State or Forei	gn
·Q.	Director		217-10-1917		]M 2□F	87	Yrs.	IVIOITIIIS	Days	riours	IVIIII.	Sep	12,	1919		<u> </u>	
	land ow		Usual Residence of Deceder 10a, State 10b, C	ounty		10c. Cit	y, Town or Lo								11	Od. Inside City Limi	ts
	Mary Fied	to	MD A	llegany	<b>y</b>		Cumb	erlan	d					1X□Yes 2□No			
	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-1 ehow dical Examinat must be notified at	Funeral Director	10e. Street and Number					10f. Zip					10g. Citizen of What Country?				
	ath wi	rai	417 Winmer	Street						1502				US	SA		
	er deg	nue	11. Marital Status 1 □ Never Married 2	Armed Forces	Vas Decedent Ever in U.S. imad Forces?  13. Was Decedent of Hispanic Origin? (Specific Cuban, Mexican, Puerto						ecify Yes Rican, etc	or No-		e - Americ ck, White,			
36	irs aft	by F	1 Never Married 25	-	1 Yes 2 I If Yes, Give Year or Dates	. WWII		1 🗆 Yes	26 No	Specify:				Specify	white	<u> </u>	
9	2 hou	ted	15. De	edent's Edu	cation		16a. Deced	dent's Usu	al Occupa	ation			16	b. Kind of B			_
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2	ifiled within I Hygiene. other then						Labore	r	T	40.14.4		4000		elanes		p	
and	ntal H ed of	Be	17. Father's Name (First, M Howard R.		ger							,		iden Suman inger	16)		
Maryland 21215-0036	2 should and Men Ie marke aumatic	ဥ	19a. Informant's Name/Rel				19b. Mailin	na Address	(Street a			·			State. Zio	Code)	
Ž	C/ m = m		Sandra Redi	nger	wife		417 V	Vinme	r Stree	et		Cu	mbei	land	MD	<sup>C</sup> 21502	
altimore,	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other to once.	1	20a. Method of Disposition 1 ØBurial 2 ☐ Crema	2 🗆 🗆	lamaval from Stat	C	lace of Dispo	natory or c	ther place	9)		ate		c. Location -	•		
Ĕ	Pages ment of ant: If It ury or o		4 □Donation 5 □Oti	ner (Specify)		° Sun	set Mem	orial F	Park	1		1/17/20	07 (	Cumbe	rland	MD	
Balt	permit. Departs Imports eny inf		21. Signature of Funeral Se	vice License	99////	//	. 22			Funer							
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8760, ©	death certificate be executed  Example All Medical and and and are as the burial-transit  The second of the second	icai Examiner	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(	Due to (or a	s a consequence	uence of):	bler	Can	ces (	with	Met	nota	N.S.		Interval Between Onset and Death	
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	w requires that been signed b should be deta	by	Part II. Other significant co	nditions cor	ntributing to death	but not resi	ulting in the ur	nderlying c	ause give	in in Part I.			Did tobac	2 No	ribute to th	e cause of death?	'n
Division of Vital Records,	<u>a</u> % C1	Completed	Hyperte	~Sio~	\							1	Was an autopsy performe	gl?	prior to con death?	esy findings availab apletion of cause of 2  No	9
ita	Phyaician: The this certificate heral director, page	Be C	25. Was case referred to m examiner?	edical						26. Place	of Death	212		7140	103	2 140	
×	Phyaician: rthis certitics ral director, r	2	1 ☐ Yes 2 No	Н	lospital: 1 🗌 Inpat		ER/Outpatien			4 🗀 1401	sing Hor	ne 5	Re <i>s</i> idenc	e 6 □Oth	er (Specify	)	
בי	ding P n. Atter t funera	ion:		ending	28a. Date of In (Month, D	ury a <i>y Year)</i>	28b. Time of Injury		8c. Injury Work			28d. Desc	hbe how	intury occurr	ed		
isio	Attending ir death. ector: Altei by the fune	cat	3 ☐ Suicide 6 ☐ C	ould not be	28e. Place of Ir	siury - At ho	mo farm etr	M Andrea		′es 2□N		28f. Locat	on /Stra	at and Alumb	or or Dura	Route Number,	
<u>≥</u>	if or Attend after death   Director: / d in by the f	Certification:	4 Homicide	etermined	building, 6	ic. (Specify	()	eet, ractory	r, onice			City o	r Town, S	State)	er or Aurar	Houle Number,	
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifier (Check only one) 1 Me	tifying Phys dical Examir	sician: To the bes ner: On the basis and manner s	or examinal	wledge, death tion and/or inv	occurred restigation	at the time	e, date and inion, deat	d place, a h occurre	and due to ed at the t	the caus	se(s) and ma and place, a	nner as sta and due to	ated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of c	rtifier				290	License	number			29d	Date signed	d (Month, E	Day, Year)	
}			000-5	100	000=	M			Dog	4009	5			01/16	107		
	8		30. Name and address of pe	erson who co	mpletee cause of	death (tem	23a) (Type, I	Print)			1	Λ	Λ.	. 1	t		
	-100		31. Date filed (Month, Day,	egrino	MO	200 G rar's Signal	Territoria.	tuit	C	umbi	enla	nd	MAY	yland	215	02	_
Septem.	Sta Registr		JAN 2			irai s Signal	Son	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ [ ] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Mary Jane Shank 17, 2007 4c. County ol Death JANUARY 9:40 A.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Reeders Memorial Home Boonsboro Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🕱 F 220-26-5405 76 Feb 23, 1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 141 South Main St. 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown Housekeeper Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James William Dayhoff Roberta Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald. Shank / son 19701 Old Forge Road Hagerstown Maryland21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 1/19/2007 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

**Physician** /Medical Examiner physicien and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed

ours after death.

• ree! Director: After this certificate has been signed filled in by the funeral director, page 2 should be det

To the Hospital within 24 hours al To the Funerei D

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Directo

Completed by Funeral

Be

**Funeral** 

Director

other than "natural", or Itame 23a or 28a-f ehow vent, the Mudical Examinar must be notified at

permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Importent: If Item 27 is marked other ti
eny injury or other treumatic avent, title
once.

VAME: SHANK MARY JANE Baltimore, Maryland 21215-0036

	Immediate Cause (Final disease or condition resulting in death)	probably  pue to (or as a conse		vareular ac	erdent	On / 2	set and Death				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last    IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 No 9   Unknown											
ysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	aldeath 3 ⊟Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day	Year				
Ď	Part II. Dther significant conditions con		ng cause given in Part I.	23e. Did tobacco	,	4 Unknown					
Completed	V				autopsy performed?						
Be	25. Was case referred to medical examiner?			26. Place of Dea	ath Check only one						
2	1 ☐ Yes 2 No	ospital: 1 Inpalient 2	ER/Outpatient 3	DOA Other: 4 Nursing H	fome 5 Residence	6 □Other (Specify)					
	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury al Work? 1 Tyes 2 No	28d. Describe how inj						
Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, larm, street, lac fy)	tory, office	28l. Location (Street a City or Town, Sta	and Number or Rural Rol te)	ute Number,				
edicai	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of my knower: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and place ion, in my opinion, death occu	n, and due to the cause( arred at the time, date a	s) and manner as stated nd place, and due to the	cause(s)				
Σ	29b. Signalure and title of certifier			29c. License number  D 3 25/8		ate signed (Month, Day,	Year)				

<u>21 WYAND\_DRIVE, KEEDYSVILLE, MARYLAND 21756</u>

DHMH 17 Rev 1/2001

3

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ROBERT GUEDENET

31. Dale liled (Month, Day, Year)

_			1 - For Amend Item Registrar	24a per v	erb., G86	ertificat	4/07 e of	lealth a d <b>hb</b> Death	and N	nental Hy	/gien Reg. N	e •.2 ()	0.7	01821
	Physic /Medi		Decedent's Name (First, Middle, La     THEODORE							2. Date of De Month		av	Year 2007	3. Time of Death
}	Exami		4a. Facility Name (If not institution, give	,		4b. City,	Town, or	Location o	f Death			c. County		10.000
	h And		Springtime Assist			Bow							e Geo	_
	Funeral Director		5. Social Security Number 6. S 577-14-7479  Usual Residence of Decedent	5ex 7. Age ■XM 2□F 88	(In yrs. last birthe	Months		If Under 2 Hours	Min.	8. Date of Bi (Month, D Feb. I	rth av, Year I	918	9. Birthpl Coun Nort	lace (State or Foreigr try) Carolin
	n the Maryland r 28a-f show notified at	tor	10a. State 10b. County MD Prince (	Georges	10c. City, Town of Mitchel		<del>. ,,</del>						16	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	n 28a n notif	iec	10e. Street and Number			10f. Zip	Code				10g. Ci	itizen of V	Vhat Coun	try?
	th wit	alD	10602 Terrapin I	Hills Ct.		20	0774					USA		
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2  N If Yes, Give Year or Dates:		13. Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spo , Puerto	ecify Yes or No Rican, etc.)	D-		e - America k, White, e	etc.
Ş	2 hou atura cal E	ted	15. Decedent's Ed	ducation	16a. D	ecedent's Usua	al Occupa	ation			16b. k	Kind of Bu	Bla siness/Ind	
21215-0036	thin 7; e. an "n Medi	Completed	(Specify only highest gra	completed)  College (1-4or 5	(G	Give kind of wor fe. DO NOT us	rk done d se retired	luring most )	of work	ing			10111000,1110	addy
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ž	hould d Mei marke matic	2	Siffus Steele  19a. Informant's Name/Relationship (	Timo Print)	10h 1	lailine Addunce	(011			Knotts				
<u>8</u>	ulth an 27 Is Ir trau	l.,	Edith Bolling/Sis	,	106	lailing Address 02 Teri chellv	rapi:	n Hil.	ls C	t,	er, City	or Town,	State, Zip	Code)
ē,	of Hea	1 3	20a. Method of Disposition		20b. Place of D	isposition (Nan	ne of	, MD.		74 Date	20c. L	ocation -	City or Tov	wn, State
Ē	Pages nent of I ant: If ite ury or of		1  Burial 2  □ Cremation 3  □ 4  □ Donation 5  □ Other (Specif		Lincoln			1	-19-	2007	Sui	tlan	d, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical jonce.		21. Signature of Funeral Service Licer	aroha		Marsha 4217 9t	d Addres	Fune	ra1	HOme, In	ıc.		17	
8	je.		23a. Part. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not	enter the mode	e of dying	g, such as o	cardiac o	or respiratory a	rrest,	,		Approximate Interval Between
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Records, P.	w requires that been signed to should be deta	by	Part II. Other significant conditions o	ontributing to death bu	not resulting in th	e underlying ca	iuse give	n in Part I.						e cause of death?
	ician: The law certificate has b ector, page 2 sl	Completed	OF Warrant and a second a second and cond and cond and a second and a second and a							24a. Was autor perfo 1□ Yes		p d	rior to com eath?	sy findings available pletion of cause of 2  No
VITAI	tysician: lis certific director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatien	t 2 ☐ ER/Outpa	tiont OFI DO	Otho			(Check only o			- 1	Aşşişted
JIVISION OF	ding Pt I. After th funeral	ation: To	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Tim		Bc. Injury Work	4 LI Nuis	2	ne 5 L Resid				Living
DIVIS	tal or Attences after death	27. Manner of Death  1 X Natural  2   Accident  3   Suicide  4   Homicide  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  M   28c. Injury at Work?  1   Yes 2   No  28e. Place of injury - At home, farm, street, factory, office  28l. Date of Injury  28l. Date of Injury  28l. Date of Injury  28l. Date of Injury  28l. Time of Injury								8f. Location (8 City or Tou	Street an vn, State	nd Numbe e)	r or Rural i	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
19	To the within 2 To the Comple	M	29b. Signature and title of certifier				D5	number	> 2			te signed	(Month, Di	ay, Year)
1	6		30. Name and address person who d							,				
	Sta	to	C. Donald George, 31. Date filed (Month, Day, Year)	M.D. 7525		y Cente	er Di	r. G1	reen	belt, N	1d.	20770	)	
	Sta Registr	0.5	JAN 2 4 2007			the s								
OHI	MH IT Rev 1/2	TOT	VIIII E001	The William of	1									700 .11

ORIGINAL

2007

WASHINGTON

U.S.A.

WHITE

4:12

Birthplace (State or Foreign Country)

10d. Inside City Limits

21713

Approximate Interval Between Onset and Death

week

YEARS.

YEARY

YEMS.

Year

Day

Month

1 Yes 2 □ No

MARYLAND

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** ROBERT LEVAN SMITH SR. 12 /Medical January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REEDERS MEMORIAL HOME BOONSBORO If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 ☐ F Yrs Director 214-28-6137 78 1928 Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10b. County ms 23a or 28a-f show Funeral Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 215 SOUTH MAIN STREET 21713 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ∏Yes 2 No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: be filed within 72 hours 3 Widowed 4 Divorced "natural", Year or Dates: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR STATE GOVERNMENT and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL SMITH MYRTLE E. HAUPT ၉ Pages 1 and 2 should Marv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I JOSEPHINE E. SMITH/SPOUSE 215 SOUTH MAIN STREET, BOONSBORO, MARYLAND Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☐ Other (Specify) 01/16/2007 LOCUST GROVE, MARYLAND ZION CEMETERY 21. Signature of 22. Name and Address of Facility Service Licensee 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 23a. Part f. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one cause on each line. Immediate Cause (Final CANCER WITH MULTISYSTEM KOLON **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ADVANCED) DEMENITA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed SEXFUE PERIPHELA VASCULAR DISENSE and Due to (or as a consequence of): physician s the burial Division or Vital Records, P.O. Box 68760. INFEGTOUS Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1☐ Yes 25 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No ٩ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after d e Funeral Direct letely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

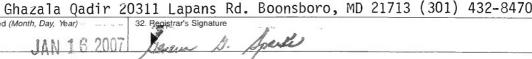
DH-4

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



**ORIGINAL** 

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			riease i	State of Ma						-	_	ible.	
		•	For State Registrar	Otato or me	-		cate of		and in	ornar riy	Reg. No.	07	0   826
			Decedent's Name (First, Middle, Last,							2. Date of De	ath		3. Time of Death
	ysicia Jedic		David Carl Sa	Lmi						Month 1	5 Day	2007	12:10 AM.
	amin		4a. Facility Name (If not institution, give			4b.	City, Town, or	r Location of	f Death		4c. County		
			2102 Beverly C 5. Social Security Number 6. Sec		(In yrs. last birth		ampst Inder 1 Year		A Hrs	B. Date of Bir	Carr	· · · · · · · · · · · · · · · · · · ·	Jane (State or Foreign
Fun Dire			220-40-9376 X	M 2 F			nths Days	Hours	Min.	(Month, Da	y, Year) /1942		place (State or Foreign ntry)
P			Usual Residence of Decedent							12/10	/1942		yland
arylar show	ig p	2	10a. State 10b. County		10c. City, Town		1					1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
the M	all line	Director	MD Carrol  10e, Street and Number	1	Hampst		rf. Zip Code				10g. Citizen of	Mhat Cour	
death with the Maryland me 23a or 28a-f show	4	ā	2102 Beverly Co	urt			1074				United		
death	9	Funeral		12. Was Decedent E Armed Forces?	ever in U.S.		Decedent of H	lispanic Orig	in? (Spec			ce - Americ	can Indian,
after or its	g		1 Never Married 2 Married	1 X Yes 2 □ N If Yes, Give	o 1964–		es 247 No	sn, mexican, Specify:	, Pueno n	ican, etc.)	}	ck, White,	
Z I Z I S-UUSO 4 within 72 hours after death with the Marylar piene. r then "naturel", or tteme 23a or 28a-f show	Ex	d by	3 Widowed 4 Divorced	Year or Dates:	1970							<sup>ty:</sup> Whi	
-C in 72	Spa	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		Give kind	Usual Occup of work done o OT use retired	durina most	of working	g	16b. Kind of B	lusiness/in	dustry
Z with	da l	E	Elementary/Secondary (0-12)	College (1-4or 5		ster	Elec	tric	ian		Elect	rica	1
id be filed fental Hygid	event,	Bec	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (		, Maiden Sumai		
2 g g 0	U	은	John O. Salmi					Velr	ma B	. Bli	tz		
Mar d 2 sh th and 7 ts m	other treumati		19a. Informant's Name/Relationship (Ty								er, City or Town		
1 and Health Fm 27	ther		Marilyn E. Salm  20a. Method of Disposition	1 - W116	20b. Place of I	Disposition	(Name of		urt Da		tead,		
ages ant of t: if it	y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery	, cremator	y or other plac		1/10	/2007	Hamps	-	
Baitimore permit. Pages 1. Department of He Important: if iten	in in		21. Signature of Funeral Service Licens	90	1			1					, 934 S.
	è g		Storen W.	Eline 1	100723						d, MD		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do no								Approximate Interval Between
Physic	ian	- 11	Immediate Cause (Final disease or condition	3	2AIN		A					10	Onset and Death
/Med Exami			resulting in death)	Due to (or as	a consequence of	f):							
LAGIII		-	Sequentially list conditions,	Sualaforne	i ourreuguarioa ul	n.							
rled	Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	20010(0.00)		,-							
oU, be executed ician and	rial-tra	Exa	resulting in death) Last	Due to (or as a	a consequence of	·):							
, 6 ×	ne pri	ca		1.									
oertifical oding phy	e as t	hysician/Med	IF FEMALE:			-0		-					
death cer e attendir	for us	lan/	in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		pic pregnancy er (specify)	,				ate of delive onth	ory Day Year
the state of	detached	yslo	1 U Yes 2 No 9 Unknown	9☐ Unknown	une or death	3 🗆 Othe	ar (specify)						
	e deta	by Pt	Part II. Other significant conditions cor	ntributing to death bu	it not resulting in I	the underly	ring cause give	en in Part I.		23e. Did t	obacco use con	tribute to th	ne cause of death?
COLUS w requires been sign	should b									1 🗆	Yes 2 ⊠No	3 ☐ Prob	ably 4 Unknown
S & C	CI I	ompieted								24a. Was	an 24b.	Were auto	psy findings available impletion of cause of
The The		CO								perfo	rmed?	death?	4
OI VITAI P Physician: Th rthis certificate	actor,	Be (	25. Was case referred to medical examiner?	11-1			Lou		of Death	Check only	оле)		
Physic rthis	al dir	2	1 Yes 2 No	lospital:			DOA Oth	4 🗆 1401			dence 6 Oth		y)
ding Afte	fune	ţ,	1 _Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	Year) 280. 11	ury	28c. Injun Worl	k? Yes 2∐N		d. Describe	now injury occur	reu	
JIVISION  I or Attending after death.  Director: After	by the	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, farr	n, street, fa	actory, office		28			ber or Rura	l Route Number,
s after	ni be	Certification:	4   Horniade	building, etc	. (Ѕреспу)					City or To	wn, State)		
Hospital or Attend 24 hours after death Funeral Director:		cai	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	ner: On the basis of	t my kn. wladga examination and	Jaath acci	arract at the tin	na, date and pinion, deat	dulace, an	id due to the	cause(s) and mi	and due to	o the cause(s)
To the within 2	mplet	Medi	29b. Signature and title of certifier	and manner sta	ted.		29c. License				29d. Date signe		
5 ¥ 5	8	7,11	MILLION	Jule	1917	)	0 0	539	8		01-0	78	-07
157	+	1	30. Name an address of person who be	mpleted cause of de	eath (Item 23a) (T	ype, Print)	- /						1021157
2+14	*		Flavio Kruter	m) 55	5 Sou	th	Carte	T.St	601	WES	STMIUS	1001	1021157
	Stat		31. Date filed (Month, Day, Year)  JAN 0 9 200		r's Signature	1							
He	gistra	ir	JAN U & ZUI	SI PARELIA	A ST	goard	V						

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

1-08-07

3. Time of Death

2. Date of Death

Month 1

Physician	
/Medical	
Examiner	

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: if Item 27 is marked other then "naturet", or Items 23s or 28s-f show eny lighty or other treumstic event, if a Medical Example armust be inclifted at 906s.

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Physician /Medical Examiner

Examiner

Certification: To Be Completed by Physician/Medical

Medical

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

James Earl Shor	tt, Sr.						1	7	2007	7:30	P.M
4a. Facility Name (If not institution, gire	re street and number)		4b. (	City, Town, o	Location	of Death		4c. Co	unty of Death		
4418 Black Rock	Road, Apt.	1	H	lampste	ead			Car	roll		
5. Social Security Number 6.		(In yrs. last bir		nder 1 Year ths Days	If Under Hours	24 Hrs. Min.	8. Date of Bird	th		place (State ontry)	or Foreign
213-52-1211	1 <b>X</b> 1M 2   F	58	Yrs.	uiis Days	riours	IVIII I.	1/23/	1948	Mary		
Usual Residence of Decedent											
10a. State 10b. County		10c. City, Tow	m or Location							10d. Inside Ci	
MD Carroll  10e. Street and Number		Hamps		. Zip Code		-		10a Citizan	of lather Con-	1 🗆 Yes	2 <b>X</b> No
	Dood A-L	1	101					-	of What Cou	1	
4418 Black Rock	12. Was Decedent 8		10.111 -	21074					d Stat		
11. Marital Status	Armed Forces?		If Yes,	specify Cuba	ispanic Or in, Mexica	igin? (Spe n, Puerto P	cify Yes or No Rican, etc.)	- 14.	Race - Ameni Black, White,	etc.	
1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2X N If Yes, Give Year or Dates:	10	1 □ Y€	s 2 D <b>X</b> No	Specify.			Sp	ecify: Whi	te	
15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's	Usual Occup f work done o T use retired	ation during mos	st of workin	ng	16b. Kind	of Business/In	dustry	
Elementary/Secondary (0-12)	College (1-4or 5	+) C	ustome					Gas a	nd Ele	ctric	Co.
17. Father's Name (First, Middle, Last	)				18. Moth	er's Name	(First, Middle,	Maiden Su	mame)		
Robert Franklin	Shortt				Dor:	is Vi	rginia	Ford			
19a. Informant's Name/Relationship	Type, Print)	19b	. Mailing Add	ress (Street	and Numb	er or Rural	Route Numbe	er, City or To	wn, State, Zip	Code)	
Amanda Maboe - G	randdaught	er 35	85 Mar	k Driv	e. Yo	ork.	PA 1740	12			
20a. Method of Disposition		20b. Place of		(Name of			ate		ion - City or To	own, State	
1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Druid		,	7 1	1/10/	2007	D-144		V1	7
21. Signature of Funeral Service Lice	··	DIUIU	22. Nam	e and Addre	s of Facili	1/10/.	2007	Daili	more, I	магута	na
8/2 (4)	A	M00723		~ .		" ELi:	ne Fune	eral H	ome, $9$	34 Sou	th
23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (dr as a	a consequence	of):	mode of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate finterval Bet Onset and I	ween
(	d.	a consequence	or):					-			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1 ☐ Pregnant at 1 ☐ Unknown	2 Fetal death		ic pregnancy r (specify)				23d	Date of delive Month		rear
Part II. Other significant conditions of Mulhiple 7/A	contributing to death bu	it not resulting in	n the underlyi	ng cause give	en in Part I		23e. Did to		contribute to the	ne cause of d	
CVA 9/05							24a. Was autop		4b. Were auto prior to col death?	psy findings a mpletion of ca	available ause of
	_							2₩ No	1 Yes	2 🗆 No	
25. Was case referred to medical examiner?						of Death	Check only o	пө)			
1 ☐ Yes 2 🕅 No	Hospital: 1 _ fnpatier	nt 2□ER/Ou	itpatient 3	DOA Oth	ar: 4 □ No	rsing Hom	e 5 Resid	dence 6	Other (Specif	v)	
27. Manner of Death  1 S Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		Time of njury M	28c. Injun Worl 1 🔲	rat ⊲? ∕es 2 🗆	- 1	8d. Describe h	now injury oc	curred		
3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	iry - At home, fa . (Specify)	arm, street, fac	ctory, office		2	8f. Location (S City or Tow	Street and Norm, State)	umber or Rura	l Route Numi	ber,
29a. Certifier 1 Certifying Pl (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination an	e, death occur id/or investiga	red at the tin	e, date an pinion, dea	d place, ar	nd due to the o	cause(s) and date and pla	d manner as st	ated. the cause(s)	)

State

31. Date filed (Month, Day, Year) Registrar

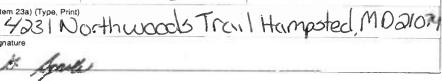
29b. Signature and title of certifie

flexancle-

JAN 0 9 2007

32. egistrar's Signature

who completed cause of death (Item 23a) (Type, Print)



D0036112

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma			ent of H ate of L		and Me		ene	07	01828
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	N.	SWI	TKE	5		2.	Date of Death Month	Day	Year	3. Time of Death 0 423 M
	Examir		4a. Facility Name (If not institution, give s MANDARIN HOUSE					RWOOD				ty of Death	CL .
\$20 °	Funeral Director		5. Social Security Number 6. Security Security Security Number 1. Secu	7. Age	(In yrs. last birth	Mont rs.	der 1 Year hs Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, ) ARCH 29,		Cour	lace (State or Foreign htry) CCTICUT
	death with the Maryland ms 23a or 28a-f show rmust be codified at	Director	10a. State 10b. County  MARYLAND MONTGOME	RY	10c. City, Town	or Location CHEVY CH	IASE					1	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	as or 24		10e. Street and Number 2905 DANIEL ROAD			10f.	Zip Code	.0815		100		of What Coun	ntry?
5-0036	i 72 hours after death with the Marylan "natural", or items 23a or 28a-1 show idical Examination into the collification	by Funeral		12. Was Decedent E Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	0		ecedent of His specify Cubar s 2 X No	spanic Orig n, Mexican	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	14. R	ace - Americ lack, White,	
0-61212	within ene. than	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			Decedent's L 'Give kind of life. DO NO	Jsual Occupa work done d T use retired) C.P.A.	ition uring most	t of working	16		Business/Ind	dustry
yland	should be filed nd Mental Hygi marked other amatic event, II	To Be (	17. Father's Name (First, Middle, Last)  NATHAN SWITKES					1	MAE DOB			ŕ	
e, Mary	1 and 2 Health a sm 27 is		19a. Informant's Name/Relationship (Ty)  ELLEN SWITKES -  20a. Method of Disposition	-		252 COI	DWATER			-	OAKS,		NIA 91401
Baltimore,	Page ment o ant: if ury or		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service ☐ Cremse	0	MT. LEBA	NON CEM	or other place		1/9/200 v			, MARYL	
ñ	Depend Depend Import		Hour KI	Leins	2-	HINES	FRINALD  NEW HA	I FUNE MPSHIR	ERAL HON LE AVENU			NG, MAR	YLAND 20904
	Physician /Medical Examiner		23a. Part1. En er the disease, or complishock, if heart failure. List only on Imme late Cause (Final disease or condition resulting in death)	Re Co	consequence of	1	OE ,	, such as	cardiac or re	spiratory arres	·		Approximate Interval Between Onset and Datah
8/60,	certificate be executed vding physicien and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Wi	consequence of	net	astax	ter	Ca	Lun	J	l	monte
O. Box 68	it the death certifica by the attending ph tached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. ff yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	3 □Ectopii 5 □ Other	c pregnancy (specify)					Date of delive	ory Day Y <i>e</i> ar
rds, P	signed signed d be de	by	Part II. Other significant conditions con	tributing to death bu	t not resulting in	the underlyin	g cause give	n in Part I.		23e. Did toba			e cause of death? ably 4 ∐Unknown
al Record	The law ate has b page 2 sl	Completed								24a. Was an autopsy performe		prior to con death?	osy findings available npletion of cause of 2 No
5	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	t 2 ER/Out	patient 3	DOA Othe	~		heck only one) 5 ☐ Resideni	e 6 <b>2</b> 0	ther (Specify	HOSPICE
Division or	ding After fune	Certification: T	27. Manner of Death  1	28a. Date of Injury (Month, Day	Year) 28b. Ti	me of ury M	28c. Injury Work 1 🗆 Y	at	28d	Describe how			HOUSE
2	in Direction		4 Homicide determined	28e. Pface of Injurbuilding, etc.						City or Town,	State)		l Route Number.
	the the	Medical	29a. Certifier (Crisck unity one)  1 N Certifying Physical Examination (Crisck unity one)  29b. Signature and title of certifier	ician: To the best of ier: On the basis of and manner stat	examination and	or investigat	ion, in my op	inion, deat	d place, and th occurred a	at the time, date	and place	, and due to	the cause(s)
	0		michly.	Falen	Agm		29c. License	7	2143	8	Jun	ned (Month, I	06, 2007
	Sta	to	30. Name and address of person who could be seen and address of person who could be se	mpleted cause of de	ath (Item 23a) (T 445 DE) 's Signature	ype, Print)	He	a MWA	ty A	VAROLI	M	7 2	1401
	Registr		JAN 0.9 200	17	W	South	20						

			For State Registrar		State o	f Maryla		artment of artificate of			ental H		0007	01020		
	es in	*	Decedent's Name	e (First, Middle, La	ist)			· ····································	2041	·	2. Date of D		001	3. Time of Death		
	Physic /Medi		A]	BRAHAM MEYE	ER SIRKIN						Month JANUARY		Day Year 2007	2:30 AM		
X	Exami	ner	4a. Facility Name (I	f not institution, giv	ve street and nun	nber)		4b. City, Tow	n, or Location	of Death		4	c. County of Deat			
	<i>f</i>	- Est	5. Social Security N	Y HOUSE	Sex	7 Ago (In tre	s. last birthday	) If Under 1 Ye	ROCKVIL		8. Date of B		MONTGOM			
И	Funeral Director		577~60-4	752	1 🖾 M 2 🗆 F	92	Yrs.	Months Da			MAY 8,	<i>ay</i> , Yea	(r) Co	hplace (State or Foreign untry) RMONT		
	land ow		Usual Residence of 10a. State	10b. County		10c. 0	City, Town or L	ocation				-		10d. Inside City Limits		
	Mary I-f sh fied a	ţċ	MARYLAND	MONTGON	ŒRY			BETHESI	)A				:	1 X Yes 2 □ No		
	or 28a	Director	10e. Street and Nur					10f. Zip Cod				10g. C	Citizen of What Co	untry?		
	23a c ust b	ra [	6525	WISCASSET	ROAD				20816				U.S.A			
	tems term	Funeral	11. Marital Status		12. Was Dece Armed For	rces?	U.S. 13.	Was Decedent of Yes, specify C	of Hispanic O Suban, Mexica	rigin? (Spec	cify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White			
36	rs after l', or l	by F	1 ☐ Never Marri 3 ☐ Widowed	ed 2 Married 4 □ Divorced	1 XYes If Yes, Giv Year or Da	2 □ No re ates: 1940-		1 ☐ Yes 2 🔯 I					Specify:			
0-	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	bel		15. Decedent's F	ducation	1940	16a, Dece	dent's Usual Oc	cupation			16b.	Kind of Business/l	HITE ndustry		
215	thin 7 e. an "n Medi	nple	Elementary/Seco	ndary (0-12)	ade completed) College (1	-4or 5+)	(Give	kind of work do DO NOT use rei	ne during mo ired)	st of workin	g	-				
21	ed wi ygien her th	Completed			5+		FO	REIGN SERV				_	EDERAL GOVE	RNMENT		
Maryland 21215-0036	12 should be filed within 'n and Mental Hygiene. R Is marked other than "'r raumatic event, <u>the Mec</u>	Be	17. Father's Name (		)							e, Maide	en Surname)			
Ž	should nd Me mark matic	은	19a. Informant's Na	C SIRKIN	Type, Print)		19b Maili	nn Address (Str		IEBE HI		hor City	or Town, State, Z	Par Carda)		
M	alth ar			SIRKIN - WI	,		ľ	5 WISCASSE						ip Code)		
ore,	ges 1 and 2 should be filed within 72 hours after death with the Marylar to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disp	osition			Place of Disn	osition (Name of matory or other)		Da		1	Location - City or 7	Γown, State		
im	Page ment of ant: If ury or			□Cremation 3 □ 5 □ Other ( <i>Speci</i> i				Y SOCIETY		1/10/	2007	BUR	RLINGTON, V	ERMONT		
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau		21. Signature of Fu	peral Service Lice	nsee			2. Name and Ad		lity						
	0 □ = @ OI		HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARY 23a. Part 1 for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she sh, or heart failure. List only one cause on each line.													
			23a. Part1 Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shall, or heart failure. List only one cause on each line.  Immediate Cause (Final													
	Physician /Medical		disease or condition resulting in death)	1	a	RRENT P	NEUMONIA							Onset and Death		
	Examiner				Due to (t	or as a conse	equence or):									
	NAVA:	ner	Sequentially list cor if any, leading to im	nditions, mediate	b. Due to (d	or as a conse	quence of):		_							
	ecuted nd transii	Examiner	Cause (Disease or i that initiated events resulting in death) L	injury	С.											
60,	be exectan a	E	resulting in death) L	ast	Due to (d	or as a conse	quence of):									
68760,	ficate be executed physician and s the burial-transit	edical			_d											
			IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outo	come pf preg	nancy						22d Date of deli-			
ğ.	death e attel d for i	Physician/M	in the past 12	months?	4☐Pregna	rth 2 ☐ Fe ant at time of		⊒Ectopic pregna ⊒ Other <i>(specify)</i>				1	23d. Date of delive Month	Pery Day Year		
P.0	at the by the tache	hys	9 Unknown		9□Unkno	wn										
Ś	The law requires that the death cert te has been signed by the attending age 2 should be detached for use a	by F	Part II. Other signifi	icant conditions	contributing to de	ath but not re	sulting in the u	nderlying cause	given in Part	l.				the cause of death?		
ord	requir een s nould	ted									1 🗆	Yes 2	2⊠No 3∏Pro	bably 4 Unknown		
3ec	ne law hasb ye 2 sh	Completed									24a. Was	psy	prior to co	opsy findings available ompletion of cause of		
a			OF 141			-					perfo 1 Yes	ormed? 2 X N	death? o 1 ☐ Yes	2 □ No		
or Vital Records,		o Be	25. Was case referr examiner? 1 ☐ Yes 2 ☐ 1		Hospital:	postiont 25	 ] ER/Outpatier	* 3□ DOA	)ther		Check only			HOGDIGE TOU		
	g Physer this leral di	n: To	27. Manner of Death	1	28a. Date o	f Injury	28b. Time o	IL SUDOA	4 LI NI		e 5∐Resi ld. Describe			HOSPICE IPU		
ior	Attending F r death. ector: After by the funer	atio	1 🔯 Natural 2 ☐ Accident	5 ☐ Pending investigation	1	n, Day Year)	Injury		/ork? □Yes 2□	No						
Division	or Atta ter de Irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	Zoe. Place	of injury - At h g, etc. <i>(Sp</i> ec	nome, farm, str	eet, factory, offic	e	28	f. Location (	Street a	nd Number or Run	al Route Number,		
Ω	pital o		20- 0-45	400-471									,			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	2 Medical Exar	ysician: To the l niner: On the ba and mann	sis of examin	owledge, deat ation and/or in	n occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, ar ath occurred	d due to the d at the time,	cause(s date ar	s) and manner as s nd place, and due t	stated. to the cause(s)		
1	To the within 24	Me	29b. Signature and	title of certifier					nse number			29d. Da	ate signed (Month,	Day, Year)		
ì	5		1 Cipa	thia 7	w Ise	llea	Some	O Ho	0058	032			UARY 8, 20	,		
-			30. Name and addre	ess of person who												
								PICE, 6001	MUNCAS	TER MII	L ROAD,	, ROC	KVILLE, MAI	RYLAND 20855		
	Sta Registr		31. Date filed (Monte		107	gistrar's Sign	St. A	and I								

Registrar DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

MONAR

JAN 09

2007

31. Date filed (Month, Day, Year)

1- CHANNES MD 6701 N- CLURUS ST

₩egistrar's Signature

07-00379

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiane

Physician/ Medical Examiner  Physician/ Medical Examiner  Physician/ Medical Examiner  Physician/ Medical Examiner  Vickie Ellen Snyder  4a. Facility Name (if not institution, give street and number)  500 South Main Street  5. Social Security Number  45. Social Security Number  46. Sex  7. Age (in yrs. last birthday)  179-52-1710  11 M 2 XF  48 Yrs.  Months Days Hours Min. Sept. 23,1958  Usual Residence of Decedent  10a. State 10b. County  Maryland Cecil  North East  10c. City, Town or Location  North East  10c. City, Town or Location  North East  10d. City, Town or Location  North East  10d. State 10b. County  Maryland Cecil  North East  10e. Street and Number  500 South Main Street  11. Marrial Status  12. Date of Death  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Month Days Yes  Age, No.  Age, (in yrs. last birthday)  If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY)  Months Days Hours Min. Sept. 23, 1958  10e. Street and Number  10g. Citizen of W.  Whith Yes, specify:  No.  Armed Forces?  Armed Forc	9. Birthplace (State or Foreign Country)  10d. Inside City Limits  1 X Yes 2 No
4a. Facility Name (if not institution, give street and number) 500 South Main Street  5. Social Security Number 179-52-1710  1 M 2 X F  48 Yrs.  4b. City, Town, or Location of Death North East  4c. County Cecil  4d. County Cecil  4d. County Cecil  4d. County Cecil  4d. County Cecil  4d. City, Town, or Location of Death North East  4d. County Cecil  4d. City, Town, or Location of Death North East  4d. County Cecil  4d. City, Town, or Location of Death North East  4d. County Cecil  4d. City, Town or Location of Death North East  4d. County Cecil  4d. County Cecil  4d. City, Town or Location of Death North East  4d. County Cecil  4d. City, Town or Location of Death North East  4d. County Cecil  4d. City, Town or Location of Death North East  4d. County Cecil  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4d. City, Town or Location of Death North East  4	of Death  9. Birthplace (State or Foreign Country) Ohio  10d. Inside City Limits 1 X Yes 2 No hat Country?  States 3 - American Indian, Black, e, etc.  White
Funeral Director  5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) Months Days Hours Min. Sept. 23,1958  Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Foreign Country) Ohio  10d Inside City Limits 1 X Yes 2 No hat Country?  States - American Indian, Black, e, etc.  White
Director  179-52-1710  1 M 2 X F 48 Yrs. Months Days Hours Min. Sept. 23,1958  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	Foreign Country) Ohio  10d Inside City Limits 1 X Yes 2 No hat Country?  States - American Indian, Black, e, etc.  White
10a. State 10b. County 10c. City, Town or Location	1 XYes 2 No hat Country?  States - American Indian, Black, e, etc.  White
Maryland Cecil North East    North East   Street and Number   Stre	States - American Indian, Black, e, etc. White
10e. Street and Number 10f. 2ip Code 10g. Clinzen of W	States - American Indian, Black, e, etc. White
the second of th	- American Indian, Black, e, etc. White
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Whit	White
11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 No	
3 Widowed 4 X Divorced if Yes, Give Year 1 Yes 2 X No specify: Spe	
15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Education (Specify only highest grade completed)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  18. Mother's Name (First, Middle, Maiden Surname)	
The state of the s	
Clerk   Ret.   Property   Prope	
3   Widowed   4   X Divorced in res. Gives rear   1   Yes 2   X No specify:   Specify    vn, State, Zip Code)	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location 20c. Location	- City or Town, State
Case 1 4 Defination 5 Other Specify: 11dy Cludde Ole Match 1 10, 2007   Newalk	, Delaware
21. Six pair of nery service Lense 22. Name and Address of Facility Crouch Funeral H	
Physician  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line.	eart Approximate Interval Between Onset and
Immediate Cause (Final disease a Pneumonia	Death
or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
Ulsease of injury that initiated but of a some of the control of t	
Proposed the part of the part	
Description of the program of the pr	f delivery Day Year
So to the post 12 months?  Note: The post 12 mon	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contributing to death but not resulting in the underlying cause given in Part I	ribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I  Yes 2 No 3  24a Was an autopsy performed?	Probably 4 Unknown  Were autopsy findings available
24a Was an autopsy performed?  25 Was case referred to medical examiner?  25 Was case referred to medical examiner?  1	prior to completion of cause of death?
Description of Death (Check only one)  1 ✓ Yes 2 No  25 Was case referred to medical 26 Place of Death (Check only one)	1 Yes 2 No
examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nursing Home 5 Residence 6	✔ Other Scene
28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occur	rred
Solution of the state of the st	ber or Rural Route Number, City
Volume 1	
The light of the l	
and manner stated  29c. License number  29d. Date signature and title of certifier	ned (Month, Day, Year)
Mayrie Dre Whill O.C.M.E. January 1	4, 2007
30 Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year)  Registrar  AN 2 4 2007	

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		1- For State Certificate			eg. No 2007	0103
Physicia Medical Exami	an/ ner	1. Decedent's Name (First, Middle, Last)  Washeeda Ali Siapoush		2. Date of Deal	Day Year	Time of Death
		4a Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	January 6	4c. County of Death	
		Woods across from 2506 Caves Road	Owings Mills		Baltimore County	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	() If Under 1 Year If Under 1 Months Days Hours	s Min	th (MM/DD/YYYY) 9. Birthpl: Foreign	rinidad
		212-13-1969 1 M 2XF 43	Yrs	Oct.1	7,1963 Countr	<del>у) 1111 ааа</del>
' auy		10a. State 10b. County 10c. City, Town or Li	ocation		10	d Inside City Limits
land f show	tor	VA FAIRFAX Chanti				Yes 2 X No
with the Maryland s 23a or 28a-f show a e notified at once.	Director	10e. Street and Number	10f. Zip Code	10	Og Citizen of What Country	?
vith the s 23a c	ral D	3501 Armfield Farm Drive  11. Marital Status 12 Was Decedent Ever in U.S 13.	20151 Was Decedent of Hispanic Orig	gin? ( Specify Yes or No.	Trinidad	Indian Black
death wi	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican		White, etc	maan, blook,
after or ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify		Specify: Wh	ite
2 hours "natu	ted		edent's Usual Occupation (Give ig most of working life, DO NOT		16b Kind of Business/Indu	stry
036 rthin 7: ne r than ledical	Completed	2	Homemaker		Own Ho	me
15-0 filed w Hygie d othe v. the N	CO	17. Father's Name (First, Middle, Last)		r's Name (First, Middle, M		71
21215-0036 uld be filed within 7 Mental Hygiene nnarked other than r event, the Medica	To Be	Mohammed Ali  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	ailing Address (Street and Num		ngar	Code)
	_	Mohammad Siahpoush/Husband 350	1 Armfield F	Farm Dr.,C	Chantilly, V	A 20151
Baltimore, MD permit Pages I and 2 skt pepartment of Health and important: If item 27 is injury or other traumat			sposition (Name of cemetery, or other place) Vall Memory	Date	20c. Location - City or Tow	n, State
Lime Page ment Tant:		4 Donation 5 Other Specify:	rdens -	1/15/07	Manassas,	
Ball permit Depar Impor		21 Signature of Funding Service Licensee	22. Name and Address of Facility 58 Catoctin	y Loudoun Circle SE	Funeral Ch Leesburg.	apel VA 20175
Physician		23a. Part I Enter the disease, or complications that caused the death. Do not en failure. List only pile cause on each libe.			est, shock, or heart A	pproximate Interval
/Medical Examiner		Immediate Cause (Final disease a Asphyxia				Between Onset and Death
	ner	or condition resulting in death)  Due to (or as a consequence of):				
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
90 =	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
ccuted transit	_	d				
30, te be ev ysician burial	ledic	UNPENDED AMENDED  IF FEMALE: 23c If yes outcome of prepagatory				
5876 rrtifical ling ph	an/N	IF FEMALE: 23b Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopid	c pregnancy	23d Date of delivery  Month Day	Year
OX (eath ce attence of or use	Physician/Medica	1 Yes 2 No 9 V Unknown g Unknown	Other (Specify)			
O. E at the c d by the tached		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Pa	art I. 23e Did to	bacco use contribute to the	cause of death?
S, P. uires th a signer d be de	ed by			1 Yes	2 Nc 3 Probably	/ 4 Unknown
ord: aw requas been	plet			24a Was a autop	sy prior to comp	sy findings available oletion of cause of
Rec The L	Completed			perfor 1 <b>Y</b> Yes		2 No
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	o Be	25 Was case referred to medical examiner?  1 Ves 2 No Hospital: Inpatient 2 ER/Outpat	26 Place of Death		Residence 6 🗸 Other; Sc	one
n of V ding Phy After th funeral of	$\vdash$	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time	of Injury 28c. Injury at Work	28d Describe h	now injury occurred	ene
tendi death rtor: /	atio	1 Natural 5 Pending FOUND FOUND 1107 hrs		No Subject asa	uitea	
Division pital or Atten ours after death erral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Moods	street, factory, office building, et	or Town, S	treet and Number or Rural F	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		4 Momicide (Specify) Woods  29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death of	ccurred at the time date and pla		from 2506 Caves Road	Owings Mills, MD
To the How within 24 h To the Fut	Medical	one) 2 Medical Examiner: On the basis of examination and/or inves				use(s)
	Ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month,	Day, Year)
		30. Name and address of person who completed cause of death (item 23a)	O.C.M.E.		January 7, 2007	
5			nn Street, Baltimore, MD	21201		
	ate		uli)	····		
Regist	(El	AULT Of COOL VINESCOOL DA LABOR				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jan 16, 2007 6:00pm м Shryock Bishop /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 15515 Bear Hill Rd., SE Oldtown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Oct 4, 1903 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 € F 213-24-6899 103 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Intern 7 is marked other then "neturel", or iteme 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or iteme 23a or 28a-f show Exemples out be notified at Oldtown MD Allegany Director 1 ☐ Yes X² ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21555 15515 Bear Hill Rd., SE Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify:white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hadessa Leary Bishop Joseph Robert Bishop 19a. Informant's Name/Relationship (Type, Print) 19b\_Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15515 Bear Hill Rd., SE Oldtown MD 21555 S. Louise Cooper daughter permit. Pages 1 and Department of Health Important: if item 27 any Injury or other tr. once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removat from State Davis Mémorial Cemetery 1/19/2007 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. NarScatpellis Puffetal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate erval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Acute Meoci MEDCAMPIAL INFANCTION ONEHOUR /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physicien end use as the burial-transit to the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Medical Certification: To Be Compieted by Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) been signed by the e should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, NEUMONIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 Inpatient 4 Nursing Home 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA To the Funerel Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature apolitile of certifier 29c. License number 29d. Date signed (Month, Day, Year) and alle anuary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 1068 Mutional Dell, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 23 2007 Registrar

07-00323 Steven Smith

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Registrar Certificate of Death	Reg. No. 2007	20
Physician lical Examine	W	1. Decedent's Name (First, Middle,Last)  Steven Gregory Smith	2. Date of Death Month Day Year January 11, 2007  3. Time of Deat 1920 hrs	h ~ ~
		4a. Facility Name (if not institution, give street and number)  University of Maryland Medical Center  4b. City, Town, or Location of De Baltimore		
Funeral Director		194-38-0240 1X M 2 F 56 Yrs	Hrs. B Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) PA	
Maryland 28a-f show any d at once.		Usual Residence of Decedent  10a. State	10d Inside City 1 Yes 2	
th the Maryland 23a or 28a-f she notified at once	E e	10e Street and Number 20047 Dutton Road 17363	10g. Citizen of What Country? U.S.A.	
filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland 40 other than "natural" or items 23a or 28a-fahe, the Medical Examiner must be notified at once	Funeral	11 Marital Status 1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No		k.
hin 72 hours aft e than "natural" edical Examine	eted by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)	of work done 16b. Kind of Business/Industry retired)	
uld be filed within 72 hours Mental Hygiene marked other than "natur e event, the Medical Exam	91		Public School ame (First, Middle, Mariden Surname)	
ages 1 and 2 should be filed with rof Health and Mental Hygiewing. If figure 27 is marked other other traumatic event, the Mental traumatic events.	To Be	19a Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of Street and Number of	othy L. Simpson or Rural Route Number, City or Town, State, Zip Code) d, Stewartstown, PA 1736	53
permit Pages I and 2 should be fill Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, I		20a. Method of Disposition  1 X Burial 2 Cremation 3 X Removal from State Crematory or other place   20b. Place of Disposition (Name of cemetery, crematory or other place)  3 Crematory or other place   5 Crematory or other place   5 Crematory or other place   7 Crematory or other place   7 Crematory or other place   7 Crematory or other place   7 Crematory or other place   7 Crematory or other place   7 Crematory or other place   7 Crematory or other place   8 Crematory or other place   9 Crematory or other place   9 Crematory or other place   9 Crematory or other place  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Crematory or other  9 Cremat	Date an . 17 ,	
permit Departm Importa injury o	1	21 nature neral Service License 22. Name and Address of Facility J	J.J. Hartenstein Mortuar , New Freedom,PA 17349	y,I
hysician /Medical xaminer		23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of)	ac or respiratory arrest, shock, or heart Approximate I Between Ons Death	et and
		Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):		
ansit	Exam	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last events resulting in death) Last d		
ate be execut physician and re burial - tran	Medical	UNPENDED AMENDED  IF FEMALE: 23c If yes, outcome of pregnancy	23d. Date of delivery	
he death certifica the attending pined for use as th	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)		ar
that the de led by the detached f	হ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of dea	
150 al			_	
e law requires that e has been signed l e 2 should be deta	mpleted		24a Was an autopsy performed? 24b Were autopsy findings av prior to completion of cau death?	ise of
ian: The law requires I certificate has been sign ector, page 2 should be c		25. Was case referred to medical examiner?	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2	
Physician: The law requires t ter this certificate has been signi eral director, page 2 should be d	To Be	examiner? 1 Ves 2 No  1 Popital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other4 Null  27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2	ise of
fureding Physician: The law requires t death cror: After this certificate has been sign y the funeral director, page 2 should be d	To Be	examiner? 1  Yes 2 No  Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA  Other  Num  27. Manner of Death 1  Natural 5  Pending	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 Prior to completion of cau death? 1 ✓ Yes 2 No 1 ✓ Yes 2 Prior to completion of cau death? 1 ✓ Yes 2 Prior	No
Interpretation of Attentions The law requires 1 spiral or Attending Physician: The law requires 1 hours after detail principles. After this certificate has been sign neral Director. After this certificate has been sign filled in by the funeral director, page 2 should be continued.	Sertification: To Be	examiner?  1  Yes 2  No  Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA  Other  Nu  27. Manner of Death 1  Natural 5  Pending 2  Accident 3  Suicide 6  Could not be determined	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2   eck only one)  ursing Home 5 Residence 6 Other.  28d Describe how injury occurred  Driver auto auto collision	No
DIVISION OF VITAL RECORDS  Septial or Attending Physician: The law requir hours after deen th meral Director.  y filled in by the funeral director, page 2 should be	Certification: To Be	examiner? 1	autopsy performed?  1 Ves 2 No 1 Ves 2 Ves 2 eck only one)  ursing Home 5 Residence 6 Other.  28d. Describe how injury occurred Driver auto auto collision  28f. Location (Street and Number or Rural Route Number or Town, State) Route 23 & High Point Road, Forest Hill, MD  and due to the cause(s) and manner as stated red at the time, date and place, and due to the cause(s)	No
To the Hospital or Attending Physician: The law requires that the within 24 hours after death  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Medical Certification: To Be	examiner?    Ves   2   No	autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 Peck only one)  ursing Home 5 Residence 6 Other.  28d. Describe how injury occurred Driver auto auto collision  28f. Location (Street and Number or Rural Route Number or Town, State) Route 23 & High Point Road, Forest Hill, MD  and due to the cause(s) and manner as stated	No
To the Hospital or Attending Physician: The law requirest within 24 hours after death  To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be death.	Medical Certification: To Be	examiner?    Ves   2   No	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 Peck only one)  ursing Home 5 Residence 6 Other.  28d Describe how injury occurred Driver auto auto collision  28f. Location (Street and Number or Rural Route Number or Town, State) Route 23 & High Point Road, Forest Hill, MD  and due to the cause(s) and manner as stated red at the time, date and place, and due to the cause(s)  29d Date signed (Month, Day, Year)  January 13, 2007	No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND 17EM#24a, per VERB. G863. 1/25/07, WS. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Ruth Virginia Truax Jan<u>uary</u> 15. 2007 30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington <u>Julia Manor Health Care Center</u> Hagerstown
Under 1 Year | If Under 24 Hrs.
onths | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 🙀 F 92 Yrs. 232**-**07-5959 November 17,1914 WV Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 126 North Pennsylvania Avenue 21750 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Supervisor Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Euclid Titus Van Gosen Virginia Esther Cordwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gretchen S. True/Daughter 13928 Heavenly Acres Hancock MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Smithsburg Crematory 01/16/07 Smithsburg, MD 21. Ignature of Funeral Servicensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) anc DYEAS 6 M Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caese, Lissass or impry that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9☐ Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 1 Yes 2 🗌 No 2 No 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner Examiner burial-transit attending physician and Division of Vital Records, P.O. Box 68760, Physician/Medicai as the esn ō the detached à signed b d be deta þ Completed

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Director

Funerai

þ

Completed

Be 2

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Medical Executing remain be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iten eny injury or other treumatic event, the Medical Exert

Baltimore, Maryland 21215-0036

with the Maryland

death

page 2 s certificate this After thi death. filled in by

Be

2

Certification:

Medical

The law requires that the death certificate be executed o the Hospitel or Attending Physicien; within 24 hours after deatl To the Funerel Director:

6

31. Date fifed (Month, Day, Year) State JAN 2 4 2007 Registrar

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be

D

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ct. Hagerst

own mo 217 2. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

\* Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health a 1- State Amend #20b, perFH, G864, 2/5/07 TT Certificate of Death	and Mental Hy	giene Reg. No. 007	01836
			Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physicia /Medic		Richard Herbert Tibbets	Januar	Day Year y 4, 2007	7:45 A M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of		4c. County of Dea	
			Suburban Hospital Bethesda		Montgomer	У
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Hours 5.77 1.2 07.52 Months Days Hours	24 Hrs. 8. Date of Bir Min. (Month, Da	th y, Year) 9. Bi	thplace (State or Foreign ountry)
	Director		577-12-8452	Nov. 1	4, 1920Wash	ington, DC
	ow ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Man Man	tor	MD Montgomery Chevy Chase			1 XYes 2 No
	death with the Maryland ms 23a or 28e-f show	Director	10e. Streel and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	23a	ral [	131 Hesketh Street 20815		U.S.A.	
	tems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Original Information of the Armed Forces?  If Yes, specify Cuban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Am Black, Whi	
36	s afte	by F	1 Never Married 2 Married 1 Tyes 2 No 1941 — If Yes, Give 1 Yes, 25 No. Specify:		Specify: Wh	
Ş	hour	edt	3 XWidowed 4 Divorced Year or Dates: 1964  15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	Industry
7.	n "n n "n n man	Completed	(Specify only highest grade completed)  (Give kind of work done during most life. DO NOT use retired)  (Elementary/Secondary (0·12)   College (1-4or 5+)	of working	TOD. KING OF DUSINGS	viridustry
213	d with	No.	4 Sonar Engineer Sci	entist	Sonar Engir	eering
P	2 should be filed within 72 hours after death with the Marylan and Mantal Hygiens. Is marked other than "naturet, or items 23a or 28e-f show is marked other than "naturet, or items 23a or 28e-f show aumstic event, the Marical Examiner must be motified at	Be		r's Name (First, Middle,		
yla	Ment Ment arked attc e	P		erine Herb		
Maryland 21215-0036	2 sh ls m raum		19a. Informant's Name/Relationship (Type, Print)Daughter 19b. Mailing Address (Street and Number 131 Hesketh Street			
e)	1 and Health Sm 27 ther t		Andrea Tibbets Bartkowski/ 131 Hesketh Street  20a. Method of Disposition   20b. Place of Disposition (Name of	Chevy Chas		
G altimore,	ages or o		Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)	2/12/2007	20c. Location - City of	
b <b>±</b>	it. Partment		21. Signature of Funeral Service Licensie  22. Name and Address of Facility  23. Name and Address of Facility		Arlington,	
Ba	permit. Pages 1 and 2 should by Department of Health and Menti Importent: If item 27 is marked any injury or other traumatic erange.		Williamy K Suy 5130 Wisconsin A	Ave. NW Was	hington, Do	
0745 07 60,	w requires that the death certificate be executed  WEXA  Deen signed by the attending physician and should be detached for use as the burial-transit  The property of the prop	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as dishock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
1-4	the death certificate by the attending phys ached for use as the	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)		23d. Date of de Month	livery Day Year
۳.	s that med b e deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribute le	the cause of death?
S g	quire en sig ruld b		Respiratory failure, Acute Renal Failure, Congestiv	'e 10'	res 2⊠No 3□P	robably 4 Unknown
obets Il Record	aw re Is be 2 sho	Completed	Heart Failure, Seizure Disorder,	24a. Was	an 24b. Were a	utopsy findings available completion of cause of
N N	The ate has page	mo.	I oft Haminhamania most comphysycacular cocident	autop perfo 1 ☐ Yes	med?   death?	completion of cause of 2 □ No
ita	sian: ertifica ctor,	Be	Left Hemipherasis post cerebravascular accident 25. Was case referred lo medical examiner? 26. Place	of Death (Check only of		
1-5	Physician: The law requ this certificate has been ral director, page 2 should	၉	1 ☐ Yes 3 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nur	sing Home 5 Resid	dence 6 Other (Spe	cify)
PE	ing P	on:	27. Manner of Death 1 → Natural 5 → Pending   28a. Date of Injury (Month, Day Year)   28b. Time of Injury   28c. Injury al Work?   28c. Injury al Work?		now injury occurred	
Sision	Attending r death. sctor: After by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be 3.8. Pleas of lawy. At home for what for the state of the s			
Š.≯	or A efter Direct in by	Certification:	Suicide 4 Homicide  4 Homicide  4 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tox	Street and Number or Ri yn, State)	Iral Houte Number,
Richard	To the Hospitel or Attending Physician: The law within 24 hours effer death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and	place, and due to the	Cause(s) and manner or	stated
X	n 24 t n 24 t ne Fui	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	h occurred at the time,	date and place, and due	to the cause(s)
	To th withir To th comp	ž	29b. Signature and little of certifier 29c. License number		29d. Date signed (Mont	h. Day, Year)
	/		M.D. D. 1765	56	1/04/07	
	>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
			Tipaporn Woodward MD 5530 Wisconsin Ave. #550 Che 31. Date filed (Month, Day, Year) 32 degistrar's Signature	vy Chase, 1	4D 20815	
	Sta Registra	-	31. Date filed (Month, Day, Year)  JAN 0 9 2007  32 degistrar's Signature			

riease Type of Fifth in Black indelible ink. Ensure All Co	
State of Maryland / Department of Health and Menta	I Hygiene 007
Certificate of Death	Reg. No.

			For Stata Registrar		State of	Marylan		artmen rtificat				lental Hy	ygienę Reg. No.	2007		837
-	Physici	an	Decedent's Name (First	st, Middle,	Last)							2. Date of D Month	eath Day	Year	3. Time	of Death
	/Media		Jashwant]									Jan.	8	2007	7:50	P. M
	Examir	er	4a. Facility Name (If not i			nber)		4b. City,		Location of			4c.	County of Dea		
	Funeval		1698 King 5. Social Security Number		S. Sex	7. Age (In yrs.	last birthday)	If Under		dersb		8. Date of 8	irth	Carro	L L th <i>p</i> lace (Stat	te or Foreign
	Funeral Director		213-02-5092		<b>X</b> M 2 □ F		39 Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D April	11.	101	Endia	o ar r araigir
	pu ,		Usuel Residence of Dece	dent												
	anyla ehov	2	10a. State 10b.	Carro	-11	10c. Cit	y, Town or Lo									City Limits es 2 XNo
	the M	ecto	10e. Street and Number	Carro	<u></u>		EIL	dersbi					10= Citi-	an of Milan C		
	urs after death with the Marylan al', or iteme 23a or 28a-1 ehow Exanticat must be motified at	Funeral Director		n' l	10 1								-	en of What Co ed Stat	·	
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9	after or ite		1 Never Married	2X Marrie		2 🔀 No					, Puerto	Rican, etc.)	i	Black, Whit	te, etc.	
5-0036	72 hours after death with the Maryland natural', or iteme 23a or 28a-1 show dical Examinar must be molified at	d by	3 Widowed 4 0	Divorced	If Yes, Giv Year or Da	ites:		1 □ Yes :	2 X NO	Specify:				Specify: Ir	ndian	
5-	"natural",	Completed	15. 〔 (Specify on	Decedent's ly highest	Education grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	il Occupa rk done d	ition <i>Juring</i> mos	t of worki	ing	16b. Kin	d of Business	/Industry	
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Maryland		To B	Navni	tlal.	Vakil						Chai	ndramaı	ni	Unknov	vn	
lan		0.4	19a. Informant's Name/F											Town, State,		
	1 and Health em 27 ither tr		Harish Vak		Son	005								rg, MD		
Jor	of it		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cre	mation 3			Place of Dispo					)ate		ation - City or		
Baltimore,	permit. Pag Depertment Important: eny injury o		4 Donation 5 0			Sou	1	TOLL  . Name an			-	1. 11, 20	M)/ Wi	nfield,	Marylan	rd
Ва	permit. Depertmine importations once.		Ami	11	ALLLA							Home & (	Cremato	D 21784		
760,	Luyacien and // // // // // // // // // // // // //	cal Examiner	23a. Part 1. El ter the dis shick, or heart fail. Immediate Callse (Final disease or caprition resulting in death)  Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns,	a	or as a consequence as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a conseq	uence of):	Con	UES		H	mri t		UNE	Approxim Interval E Onset an	Between
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s, P	res that signed to be det	by P	Part II. Other significant	conditions	s contributing to de	ath but not resi	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did	tobacco us	e contribute to	the cause o	of death?
ord	w requir been si should	ted						_				1 🗆	Yes 2	1No 3□Pi	robably 4 [	Unknown
Rec	e law hes t	Completed										24a. Was		24b. Were au prior to death?	utopsy finding completion of	s available cause of
la	icien: Th certificate rector, pag	င္ပ	25. Was case referred to	modinal								1 ☐ Yes	2 110		2 <u>17</u> 10	
₹		00	examiner?	medicai	Hospital:	patient 2	FR/Outestine	t 3 🗆 DO	A Othe	r		Check only				
of	g Physie ter this	<u>ا</u>	27. Manner of Death	1-11	28a, Date o	f Injury	28b. Time of		Bc. Injury Work	4 🗆 1401		28d. Describe		Other (Spe	city)	
ion	들은 중 호	atio	2 Accident	Pending investigat	ion	n, Day Year)	Injury	м		es 2 □	No					
Division of Vital Records,	or Atte	Certification;	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not determine	286. Place	of Injury - At ho g, etc. (Specify	ome, farm, str	eet, factory	, office		2	28f. Location City or To	(Street and wn, State)	Number or Ru	ural Route Nu	ımber,
	ours a ours a neret l		29a. Certifier	Certifying	Physician: To the	best of my kno	wledge, death	occurred a	at the time	e, date and	d place, a	and due to the	cause(s) a	and manner as	stated.	
	To the Hos within 24 h To the Fur completely	edicai	(Check only 2 1 1	Aedical Ex	aminer: On the ba and mann	sis of examinal	tion and/or inv	restigation,	in my op	inion, deat	th occurre	ed at the time,	date and	place, and due	to the cause	∋(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title o	f certifier .					License	1 -			-	signed (Mont		
	toch		· / new	1ch		ING		-	40	570			JANU	(ARY)	10,20	07
	5		30. Nam and address of	person wh		of death (Item	23a) (Type,	Print) # 32	TPIL	DiNI	15/	Murc	Ni	(ARY)	1,7	
	Sta	te	31. Date filed (Month, Da		32 19	gistrar's Signa	ture		,,,,,	-,,,,,		.,,	/-()	1211	1 /	
3.	Registr	ar	JAN	10 2	2007	gistrar's Signa	M Ap	edi								
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DHMH 17 Rev 1/2001

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AMEND ITEM/24a, perPHYS. C863 1/24/07 US

AMEND OF MARKET OF PROPERTY C864, 276/07 ANS Mental Hygiene

Certificate of Death

Reg. No. 2 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DOROTHY В. WILLIAMS 01 2007 M 14 1738 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 214-07-3151 89 Director Apr. 6, 1917 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1X Yes 2 □ No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 14314 Niners Lane  $\frac{-25}{}$  21502 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by Specify: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert E. McClellan Ethel Marie (McKenzie) McClellan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rodney Williams Grandson 14314 Niners Lane, Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Pk Jan 18 07 Frostburg, MD eture of Euneral Service Licenses 22. Name and Address of Facility Hafer Funeral Service, 1302 National Hwy., LaVale, MD 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. LEFT LOWER LOBE PNEUMONIA /Medical Due to (or as a consequence of): Examiner b RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ALZHEIMERS, NORMAL PRESSURE HYDROCEPHALUS 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe this certificate 1□ Yes 2 No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: 2 ER/Outpatient 3 DOA 1 Npatient Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and tife of certifier 29c. License number 29d. Date signed (Month, Day, Year) Merly ma 15 107 D46346 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 625 KENT AVENUE CUMBERLAND, MD 21502 HUMA SHAKIL, M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.
AMEND TIEM#31 perDVR C863 1.724/07 WS
State of Maryland 7 Department of Health and Mental Hygiene

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	Funeral Director	5. Social Security Number 219-20-4541		X	ge (In yrs. i 79	last birthdey) Yrs.	Months	Days	If Under 24 Hrs Hours Min		ay, Year)		place (Stete or Foreign ntry) LETT, VA.	
	and **	Usuel Residence of Decede  10e. State 10b. C			10c. City	y, Town or Loc	etion						10d. Inside City Limits	
	er death with the Marylan terms 23e or 28e-f show ner must be notified at unerral Director	MD F	REDERI	r CV	TUM	MTMCDIT	D.C.						1 ☐ Yes 2 ☒ No	
	or 28e-f s	10e. Street end Number	KEDEKI	LCK	E,M	MITSBU		p Code			10g. Citiz	en of What Cou	ntry?	
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	r tems 23 diner must Funeral	11. Meritel Status		12. Was Decedent Armed Forces	Ever in U,	S. 13. V			lispanic Origin? (S an, Mexican, Pue	Specify Yes or N	o- 1	4. Race - Ameri Black, White		
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anc	The first Hall Hall Hall Hall Hall Hall Hall Hal	17. Fether's Name (First, Mi	ladie, Last)	D01111 0					18. Mother's Na	ıme (First, Middle	, Maiden 3	Sumame)		
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	/Medical   Examiner	Immediate Cause (Final disease or condition resulting in death)  e. LONGESTIVE HEATT FAILURE  Due to (or as a consequence of):												
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<u>.</u>	D 00 0	Part II. Other significant co	nditions cor	ntributing to death b	ut not resu	ulting in the un	derlying	cause giv	ren in Part I.	23b. Did	tobacco u	se contribute t	o the cause of death?	
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>	8 00	examiner? 1 ☐ Yes 2 ☐ No	ħ	lospital: 1 ☐ Inpati	ent 2	ER/Outpetient	3□ D	OA Oth	or.	Home 5 ☑ Res		□Other (Speci	fy)	
0	nerel	27. Manner of Death 1 ☑ Naturel 5 □ P	ending	28a. Dete of Inju (Month, Da	ry Year)	28b. Time of Injury		28c. Injur Wor		28d. Describe			··	
<u>\o</u>	Attending or death.  Sctor: Afte by the fune	2 Accident in	vestigation	,			М		Yes 2□No					
Division	tal or Attending Presents after death.  In Director: After the funered in by the funerecent of the fun		ould not be etermined	28e. Place of In building, e	ury - At ho c. <i>(Specif</i> y	me, farm, stre	et, fector	y, office		28f. Location City or To	(Street and wn, Stete)	Number or Run	al Route Number,	
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29a. Certifier 1 Cer (Check only 2 Mer	rtifying Phys dical Examb	siclan: To the best ner: On the basis of end menner st	f examinat	wledge, death ion end/or inv	occurred estigation	et the tir n, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) a date and	and manner as s place, and due t	stated. o the cause(s)	
	To the vithir comp	29b. Signature and title of co	ertifier		1		29	c. Licens	e number		29d. Date	signed (Month,	Day, Year)	
		Dall.	RICK	while.	4			MO	12963	68	JANU	ARY 19.	2007	
	۵	30. Name end address of pe	erson who co	ompleted cause of	leeth (Item	23a) (Type, F	Print)	524	5.	WASHI	NG7	BN 57		
	8	DWIGHT				MO		62;	12963 5-1745B	420	PA	173	325	
	State Registrar	31. Dete filed (Month, Dey,	Year)	2 4 2007	er's Signat	ture Luci	4 1	Longe	E.A.	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1 Per Phy g864 2/07/07 TH Certificate of Death Reg. No. 1 - For State Registra 1. Decedent's Name (First, Middle, Last) Francis 2. Date of Death 3. Time of Death **Physician** Leo Franklin Year Wempe Jan 21 2007 4:02 am /Medical 4a. Facility Name (If not institution, give street and number)
Beverly Living Center of Cumberland 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 219-03-9772 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Days Hours 87 Director Jul 16, 1919 MD Usual Residence of Decedent Allegany the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD 77 is marked other than "natural", or itame 23a or 28a-f shov traumatic event, it e Madical Experient man be notified at Cumberland 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 601 E. Oldtown Road 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be fited within 72 hours efter death with inent of Heelth and Mental Hyglene. 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) foreman Allegany Ballistics Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, To Be Joseph U. Wempe Mary Ann (Brinker) Wempe 19a Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) niece Department of Heelth a importent: If Item 27 is any injury or other tre once. Cumberland MD 21502 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State St. Mary's Cemetery 1/24/2007 <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Cumberland MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebro Vascula disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy rmed? 2DI No 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No Certification: To 2 TER/Outpatient 3 DOA 42 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After? 1 Alatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00033280 30. Name and address of person who impleted cause of death (Item 23a) (Type,/Print) h 625 . Registrar's Signature State JAN 2 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #6 Per Parates 3 May 2970 7 Department of Health and Mental Hygiene 1 - For A State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ar nes 1145 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
1-3-1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2/□ F Macksville, WV 75 Yrs. 234 46 6662 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 X Yes 2 No Director MD Hagerstown Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 17805 Greenberry Circle USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 □ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Washington County I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Schools Secretary other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 Is marked oth Jury or other traumatic even Be Arvella Harper May Homer A. May 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Ann Sarno - Daughter 1938 Londontowne Dr. - Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: If any Injury or once, North Fork Memorial 11-17-2007 Riverton, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licenses POB 215 Franklin Basagic Funeral Home 26807 143.49 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has blirector, page 2 s autopsy performed 2 No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature Year) 31. Date filed (Mo State 2007 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Wiebe Russell 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Maryland University of Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 ☐ F 726-16-1436 **Director** July 6 1927 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2√☐ No Director Hagerstown Maryland Washington 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number or be Pages 1 and 2 should be filed within 72 hours after death with tonnt of Heatth and Mental Hygiene. ns 23a ( must b 21742 U.S.A. 18603 Orchard Hills Parkway Completed by Funeral ırai", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "naturai", or 1 ☐ Yes 2 🗓 No White Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Postman Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ever Helen VanHorn ဥ Frank James Wiebel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21742 19a. Informant's Name/Relationship (Type. Print) 27 Helen M. Wiebel (wife) 18603 Orchard Hills Parkway Hagerstown Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 1-17-2007 Hagerstown Maryland 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Sonature of Fun ral Service Licenses 1331 Eastern Bld. N. Hagerstown Mayrland 21742 Part I. Enter the diseas shock, or heart failure. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 24 days Immediate Cause (Final Physician disease or condition resulting in death) /Medical sequence of) Examiner Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, To the Funeral Director: Aft

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year) 1-11-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU/ 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 9, 2007 eona Sally Williams 0040 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll Hospital Center Westminster Carroll Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 F 69 Yrs. 214-34-3911 Dec 22, 1937 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location Tanevtown 1 Yes 2 □ No Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 130 Carnival Drive 21787 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: Specify: 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Eldercare Home Health Aid 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Francis Gertrude Brothers Charles William Smith, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 130 Carnival Drive, Taneytown, MD 21787 Cynthia L. Humple, daughter 20b. Place of Disposition (Name of camptary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 01/10/2007 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Junature of Funeral Service Licensee M01191 91 Willis Street, Westminster, MD 21157 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipk, or heart failure. List only one cause on each line. Interval Between Onset and Death min date Cause (Final Severe disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2 □ No 1□ Yes @□No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

signed by the attending physicien and doe detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, been certificate has Attending Physicien: funeral director, this After death. To the Hospitel or Attend within 24 hours after death To the Funeral Director: filled in by the WIL 3

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

238

"natural, or

and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental by Important; if item 27 is marked oth any injury or other traumatic event once.

Physician

Examiner

/Medical

the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Certification: To

Medical

State

Registrar

29b. Signature and title of certifier

31. Date liled (Month, Day, Year)

Nayan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vaywa/a

**JAN 09** 

MI

32. Registrar's Signature

with the Manyland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

1130

29c. License number

23443

29d. Date signed (Month, Day, Year)

Baltimore Blvd, Scite B, Westminster, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	Marylar	•		nt of He te of D		ind Me		gienę leg. No 0 0	7 01844
	Physicia	an	Decedent's Name (First, Middle, Last)  T							:	2. Date of Dea Month		3. Time of Death
	/Medic	al .	Les  4a. Facility Name (If not institution, give	ter Harl		Wagamai		Town or	Location of	f Death		4c. County o	07/3/30 PM
1	Examin	er	80 Ricketts Mill		51)			lkton		Deatti		Ceci	
	Funeral		5. Social Security Number 6. Sec	7.		last birthday)		r 1 Year	If Under 2	24 Hrs.	B. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director		100-14-9007	M 2□F	85	Yrs.		Duyo		I N	March 6	, 1921	Maryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	r 28a-f ehow	to	Maryland Cecil		E	1kton							1 ☐ Yes 2 🛱 No
	or 28.	Directo	10e. Street and Number				10f. Zi	p Code				10g. Citizen of Wh	hat Country?
	s 23a	rai	80 Ricketts Mill		A.C	0 1.2		21921		2.0			States
	72 hours after deeth with the Maryland Instural, or Items 23e or 28e-f show dical Examinar must be notified at	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 ☑ Yes 2[ If ¥es, Give Year or Date:	s? Wor]	ld 13. Y	f Yes, spe	ecify Cubar	n, Mexican,	, Puerto R	ify Yes or No- ican, etc.)	Black,	- American Indian, , White, etc.
5-0036	ral', o	by	3   Widowed 4 □ Divorced	If Ares, Give Year or Date	_War ]	II	1 □ Yes	2 <b>∏</b> No	Specify:			Specify:	White
50	72 hours 'netural',	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	kind of w	ork done d	lurina most	of working	9	16b. Kind of Bus	iness/Industry
121	yene.	mpi	Elementary/Secondary (0-12)	College (1-4d	or 5+)			use retired) Engi				Airli	no
<b>d</b> 2		0	17. Father's Name (First, Middle, Last)			1	rgiit			r's Name (	First, Middle,	Maiden Sumame,	
/lan	Vid be	To B	Howard Russell W	agaman					Rut	th Id	ella Ha	arbaugh	
Maryland 2121	s 1 and 2 should be filed f Heelth and Menta! Hyg Itam 27 le marked othe other treumatic event,		19a. Informant's Name/Relationship (Ty				•					r, City or Town, S	1 1
	permit. Pages 1 and 2 Department of Heelth a Important: If Itam 27 le any injury or other tree		Barbara G. Peirs  20a. Method of Disposition	on/Daugh		584 S			I	Da	to		ware 19977 Dity or Town, State
Baltimore,	ayes nt of h t: if its		1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from Sta	te Gi	cemetery, cren Inin Ma	natory or	other place		anua:	ry 18,		
Hi	permit. Page Department Important: II any injury or once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	99) .	Mer	norial	Park Name a	ing Addres		2007			Maryland
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			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caus	sed the deat								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ev	de	Sta	9.1	2	CV	IA			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	quence of):	/						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	quence of):					7.5		
3	ecuted and i-transit	Examiner	that initiated events	3.									
Ö			resulting in death) Last	Due to (or	as a conseq	quence of):							
8760	icate be ex physicien s the buria	edical		d									
Вох 6	death certificate e attending phys d for use as the	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcor								23d. Date	of delivery
	death e atte	Physician/M	in the past 12 months?  1 Yes 2 No	1 ☐ Live birth	t at time of d		Ectopic p Other (s	pecify)				Mont	
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ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical						26. Place	of Death (	1 ☐ Yes Check only on		Yes 2 1 Ho
/ \	Ø ≅ ₩	2	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpa	atient 2	ER/Outpatien			4 🗀 Nur	sing Home	e 5 Treside	ence 6 □Other	(Specify)
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Division of	death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of	Injury - At h	ome, farm, stre	M et factor		′es 2□N		If Location (S	treet and Number	or Rural Route Number,
Θį	afor A safter of in by	Certification;	4 Homicide determined		etc. (Specif		301, 100101	19, 011100			City or Town		or ristar riodic restriction,
	Hospitel	edicai (	29a. Certifier 1 Certifying Physical Examination	sician: To the be	est of my kno	owledge, death	occurred	at the time	e, date and	place, an	d due to the c	ause(s) and man	ner as stated.
	F - 1 0		one)	and manner	stated.		oongano	и, ил ппу ор	miori, dout		at the time, a	ate and place, an	od dde (O the Cadse(s)
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<b>)</b>	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier	and marrier		11.1	29	c. License	number	/ / 11	16	9d. Date signed	Month, Day, Year)
	To the H within 24 To the Fi complete	Med		)	of death (Iten	m 23a) (Type. I		c. License	number 05	64	49	9d. Date signed	Month, Day, Year)
_	To the H within 24 To the Fi	Med	29b. Signature and tyle of certifier	ompleted cause of	of death (Iten	11 Wgs		DO tigh	number 05	64 SL	49	9d. Date signed (1116)	Month, Day, Year)  O7  1Kton MD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month Howard James Weller, Jr. Januar 17,2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F 220-16-2857 September 13,1924 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8903 Corner Road 21750 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard James Weller, Sr. Olive M. Mellott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henrietta M.Weller/Wife 8903 Corner Road Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 01/18/07 Smithsburg, MD 21. Fature of Funeral Service Licenses 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that eaused shock, or heart failure. List only one cause on each li ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Vear 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No autopsy performed? Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed use as the burial-trai Division or Vital Records, P.O. Box 68760. the attending physician signed by certificate has Hospital or Attending Physician: After this

Examine Physician/Medical Completed by Be Ţ Certification:

23b. Was decedent pregnant

1 Yes 2 No 27. Manner of Death 1 Antural

5 ☐ Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

15 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

D

Medical

Day, Year)

32 Registrar's Signature

OPAL ST. HAGERSTON 1/22

To the Hospital Strate death.

To the Funeral Director: Af

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ANUMAY 12, 7007 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number Examiner OSPITA 8. Date of Birth (Month, Day, Year) Jan. 18, 1942 Age (In yrs. last b Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 □ F 64 264-60-9487 Yrs. Director Georgia Usual Residence of Decedent 10c. City, Town or Location Show 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho: Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2KINo Director York PA New Freedom 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17349 107 Reehling Road U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 No à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Consultant Contracting Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Elmer F. Walker Gladys I. Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Geraldine Diane Walker 107 Reehling Rd., New Freedom, PA 17349 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 18, 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Jan. Oak Grove Cemetery Wildwood, FL 4 □ Donation 5 □ Other (Specify) 2007 permit. nature of uneral Service License 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician HEMON Due to (or as a consequence of): day /Medical Examiner Sequentially list conditions, if any, is away to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine Ancreatitic e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and TI burial-tran P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ ate has been signated bage 2 should b 1 ☐ Yes 2☐ NO 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 1∐ Yes 2 210 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ( No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

12

within 24

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCORGE

DHMH 17 Rev 1/2001

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APOSTOLIDES 600 NORTH WOLFE STREET, BALTIMORE

29d. Date signed (Month, Day, Year)

JANUARI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend #17 per PH C86 3 3 12 1 - State Registrar	ሪታንያ Cer	artment of H <i>rtificate of L</i>	lealth and M D <i>eath</i>		ne . No.2 0 0 7	01847	
¥	Physici		1. Decedent's Name (First, Middle, Last)				Date of Death     Month	Day Year	3. Time of Death	
	Physici /Medic	al	William Jennings Wenne 4a. Facility Name (If not institution, give street and number)	x J.		Location of Death	January	14 266 4c. County of Dea	7 3115 HM	
	Examin	er	Washington County Hospital		Itagers			4c. County of Dea	i i	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State or Foreign		
, žás	Director		218-38-1994	Yrs.	Months Days	Hours Min.	(Month, Day, Youly 29,	1941 Mar	yland	
	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or Items 23a or 28a-f show afte event, the Medical Examiner must be notified at			, Town or Loc	cation				10d. Inside City Limits	
	e Ma 3a-fs tiffied	Director	Maryland Washington Hage	rstown					1. Yes 2 □ No	
	or 28	Dire	10e. Street and Number		10f. Zip Code		10g	. Citizen of What C	country?	
	ath w	ra	849 Mulberry Avenue		21742		USA			
	er de Items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  1. Discontinuous Marital (NT Marital)	i. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh		
36	rs aff	by	1 □ Never Married 2 ሺ Married 1 □ Yes 2 ሺ No If Yes, Give Year or Dates:	1	☐Yes 2∏ No	Specify:		Specify:	ite	
ĕ	2 hou atura	De le	15. Decedent's Education	16a. Deced	lent's Usual Occupa	ation	16	b. Kind of Business		
215	hin 7. 9. an "n Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. E	kind of work done of OO NOT use retired	during most of work )	ina 1	mmercial		
7	d wit	5	6	Lead C	arpenter		Re	sidentia	1 Construction	
nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma	iden Surname)		
Уa	ould Men narke	ဥ	William Jennings Wenner, <del>Jr.</del> SR.				uline Mon		<u> </u>	
Mai	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print)				al Route Number, C			
e,	1 and Healt em 2 ther		Barbara Ann Wenner, wife  20a. Method of Disposition 20b. Pl	849 M	ulberry A	Avenue, H	agerstown	. Maryla c. Location - City o		
Jor	ages nt of t: If It		i ka bullati z 🗆 Cremation 3 🗆 Removal from State		sition (Name of natory or other plac	i i		•		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	-	4 □ Donation 5 □ Other (Specify) Harm  21. 8ignature of Funeral Service □ Censee	ony Br	Name and Address	emetery l	./19/2007	Myersvil	le, Maryland	
Ba	permi Depa Impo any It								uneral Home aryland 21701	
-	10000		23a. Part1. There the disease, or complications that caused the death shock on heart failure. List only ause on each line.						Approximate	
	Physician		Immediate Couse (Final						Interval Between Onset and Death	
8	/Medical		disease or condition resulting in death)  a. Due to (or as a consequ	ence of):					Hours	
	Examiner		Sequentially list conditions Bowel Pi	erfora	-tion				Hours	
7	pa #	iner	Sequentially list conditions, if any, leading to immediate cause. Linet Underlying Cause (Disease or injury that initiated events	Tar Charles	GOC					
V	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	farct	ion				itours	
68760,	ificate be executed g physician and as the burial-transit		Sue to (or as a consequ	silce oi).		*				
387	tificate ig phys as the	edical	d					<del></del>		
			IF FEMALE: 23c. If yes, outcome pf pregnant					23d. Date of de	diven	
Box	death e atte d for	icia	in the past 12 months?		Ectopic pregnancy   Other <i>(sp</i> ec <i>ify)</i>			Month	Day Year	
0	t the	Physician/M	9 ☐ Unknown							
S,	ires that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but not result			en in Part I.	23e. Did tobac	co use contribute t	to the cause of death?	
Division or Vital Records, P.O.	equire sen si ould b	Completed by	Cody-lopathy Respira			<del></del>	1 ☐ Yes	2 <b>2 N</b> o 3 □ F	Probably 4 Unknown	
ec	stcian: The law requir certificate has been si rector, page 2 should	ple	Anemia Severe Acute renal failure Corona	elect	trolyte d	Jerangemen	24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of	
医医	Physician: The Is this certificate har ral director, page 2	8	Acute renal failure corone	ary ar	-tery bi	sease	performed 1 Yes 2 □	d? death?		
<u>Zit</u>	lcian Sertifi ector	Be	25. Was case referred to medical			26. Place of Death	(Check only one)			
o	Phys this al dir	2	1   Yes 2 No Hospital: 1   Impatient 2   E 27. Manner of Death 28a. Date of Injury			4 LI Nursing Ho	me 5 Residenc		ecify)	
UQ	or Attending Ph after death. Director: After th in by the funeral	ion	1 ☑ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	Work	/ at ⟨? Yes 2 □ No	28d. Describe how	injury occurred		
<u>is</u>	l or Attendafter death Director:	icat	3 Suicide 6 Could not be 28e Place of injury - 4t har	ne. farm. stre			28f Location (Stree	et and Number or E	Sural Route Number.	
<u>S</u>	after after I Dire d in b	Certification:	4 ☐ Homicide determined building, etc. (Specify,	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, S		aras riodic rioribes,	
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.		29a. Certifier (Check only 2 Medical Examiner: On the basis of examinating the control of the basis of examinating the control	vledge, death	occurred at the tim	ne, date and place,	and due to the caus	se(s) and manner a	is stated.	
	the Phin 24 the F	Medical	one) and manner stated.	on and/or miv						
	To Your	-	29b. Signature and title of certifier		29c. License			Date signed (Mon		
,		}	80mm mp			16031	20	Loury	14,2007	
_	3		30. Name and address of person who completed cause of death (Item Frank J. Collins IIIIO Medica			suite 24:	2 Hagerst	own md	21742	
	Sta Registr		31. Date filed (Month, Day, Year)* 32. Tegistrar's Signat		meli					

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. UU / - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 5, 2007 **Physician** 12:33 P.M Lydia G. Young /Medical 4a, Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3124 Gracefield Road, KC307 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 22,1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1□ M 2 F 81 Yrs. Days Months Hours Hungary 009-20-6128 **Director** Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturat", or items 23a or 28a-f show other traumatic event, the Mcdical Examinar must be notified at Maryland Silver Spring 1 ☐ Yes 2 No Montgomery Director filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3124 Gracefield Road, KC307 20904 United States Completed by Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fand Mental F Yolan Beck Jeno Garai ပ 19a Informant's Name/Relationship (Type, Pript) William B. Young -husband 19b Mailing Address (Steet and Number or Rural Boute Number City or Town, State, Zip Code) 3124 Gracefield Road, KC307 Silver Spring, Md. 20904 permit. Pages 1 and 2 st Depurtment of Health and Importent: If item 27 Is m any injury or other traum oncs 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 1/8/2007 Alexandria, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee มชานาใช้ ซึ่งใช้พี่สาdt Funeral Home, PA 4400 Fowder Mill Road Beltsville, Maryland 20705 1500 mald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ateriosclerotic Cardiovascular Disease Physician years /Medical Due to (or as a consequence of) **Examiner** Hypertension years Sequentially list conditions, if any, leading to firm ediale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Tua to for as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 Yes Attending Physician: ours after death.

neral Director: After this certifical filled in by the funeral director, f Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 To the Hospitel within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D34590 January 8, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy E. Fried, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

State Registrar 31. Date filed (Month, Day, Year) JAN 0 9 2007



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

amend item 19b per fh 864 2-2-07 vt. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10e per fh 8863 1-30-07 vt.

amend item 10e per fh 8863 1-30-07 vt.

Amend Items 23a, b, 25 per ME 6863 01/23/67dhb

Reg. No. 0 7 . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death January 16, 2007 **Physician** RICHARD DARRELL AMIS, SR. 3:47 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Carroll Westminster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec. | 6 , 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex **Funeral** 1 ₩ 2 □ F 218-58-0993 Yrs. 54 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or itama 23a or 28a-f ahow the Medical Exercity of most by notified at 1√ Yes 2 No **Funeral Director** MD Carroll New Windsor 10f. Zip Code 10g. Citizen of What Country? dge\_Road 21776 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Grade 9 College (1-4or 5+) Truck Driver B & S Trucking traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tent: If Item 27 is marked other. James Amis Thelma Mitchell 19 - Hailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Angel Fay Hook daughter 7 Atlee Ridge Road New Windsor, MD other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State ō permit. Page Department of Importent: If any injury or once. West Arundel Crematory 1/20/07 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. Gy / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 15 HOURS INTRAPARENCHYMAL HEMATOMA (2) HEMISHERE /Medical Due to (or as a consequence of): Examiner Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) be detached P. 0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? MULTIPLE SCLEROSIS 24a. Was an autopsy performed2 3 No 1 Yes 1 ☐ Yes After this certification, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes -3 No Medical Certification; To 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 2007 DOUS-9552 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 A POOLE RD WESMINSTER COURISHBUKEAR ( MAGANNA 32. Registrar's Signature 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month TOEBE aman 2) 200 /Medical 4s. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Northwest Hospital Baltimore Randallstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🕅 F May 10, New York Director 86 075-16-9945 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 ☐ Yes 2√☐ No Director Owings Mills 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò 4730 Atrium Court #610 23a 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: white 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ social worker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fin and Mental H Be Abraham J. Schwartz Celia Lavender ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s of Health an item 27 Is I Merrill Alterman/daughter 321 Dixie Drive Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Signature of Funeral Side Licensee Wagte 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Parti Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical or as a consequence of) Examiner CE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? 1☐ Yes 2 No 9☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. be detached the 9☐Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 10 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA ၉ in by the funeral Date of Injury (Month, Day Year) 27. Manner of Death 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death, 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deam occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day,

JAN 2 5 2007

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30) H

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** AMUARY 11-240 PM Tore Knut Anderson 22-2007 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SACTIMON 22 10 ARHAMYTON EIBN BURNIE ANNE MEDICAL CENTRE HEUNDE 5. Social Security Number If Under 1 Yea If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 XM 2 ☐ F Hours 85 267-38-7508 Director May 18, 1921 Sweden Usual Residence of Decedent 10c. City, Town or Locetion 10a. State 10b. County 10d. Inside City Limits 28a-f show Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo MD Anne Arundel Hanover 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must once. Funeral 7548 Old Telegraph Road 21076 Sweden 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Tore Amerso 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No ģ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Adm<u>inistrative Assistant</u> Swedish Consulate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Karl Anderson Julia Segerman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ralph Anderson / son 30 G Amberstone Ct., Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Cremation | 01/24/2007 | Stevensville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. MO1459 1 Second Ave SW, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MEUMONIA /Medical Due to (or as a consequence of): PAILURE Examiner BYNT 257 MC EAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician s the burial Division or Vital Records, P.O. Box 68760 Physician/Medical as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 **≌**Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an s certificate has t irector, page 2 s nours after death. Ineral Director: After this certificative filled in by the funeral director, p. 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tive of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2007 less of person who completed day se of death (Item 23a) (Type, Print) 3.01 Apos Drive

State Registrar 31. Date filed (Month, Day, Ye

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2007 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Dumber If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 1 Year Days 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 217-62-948 Usual Residence of Decedent Hours 1□M 2XF Yrs. Maryland Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is markad other than "natural", or Itams 23a or 28a-f shov other traumatic avent, the Medical Examinar must be notified at 1 XYes 2 □ No Director more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code T61 Funeral O 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Pace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖔 No Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H is markad of 110 ear 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 205. Place of Disposition (Name of 20a. Method of Disposition
1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Locatin - City or Town, State comotory, cromatory or other place) to#: \* 4 ☐ Donation 5 ☐ Other (Specify) oudon 22. Name and Address of Facility
Joseph L. Russ Fuperal H
2222 W. North Ave. Balto. 21. Signature of Funeral Service Licenses 23a. Pan. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Cardiac Tamponade Minutes /Medical Due to (or as a consequence of): Examiner Hemopericardium Minutes Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury burial-transit Aortic Dissection Days that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 4□Pregnant at time of death P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Hypertension 1 🗌 Yes 2 10 3 ☐ Probably 4 ☐ Unknown Completed Morbid Obesity 24a. Was an autopsy performed Type II Diabetes Mellitus 2□No 1 Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: P 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of this completely filled in by the funeral 27. Manner of Seath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) luthe us M MIT, D37359 January 23, 2007

Registrar DHMH 17 Rev 1/2001

State

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GORNE

900 Caton Avenue Baltimore, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Charles .

Kris M. Shekitka,

JAN 2

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar		Cer	tificate of i	Death		Re	eg No.			
Physician/	1. Decedent's Name (First, Midd	le,Last)					2. Date of Dea		3 Time of Death		
ledical Examiner	Ellen V. Brask						Month January 4	Day Year , 2007	1341 hrs		
	4a Facility Name (if not institution 16001 Shady Grove F	on, give street and nu	mber)	41	c. City, Town, or L Rockville	ocation of Dea	th	4c. County of Death  Montgomery			
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24H	rs. 8. Date of Bir	th (MM/DD/YYYY)	9 Birthplace (State or		
Director	534-94-1018	1 M 2 X F	4	O Yrs.	Months Days	Hours M	Dec. 9	, 1966	Washington		
daryland 28a-f show any 1 at once, ector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d In  WA King Kirkland										
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 12110 N. E. 14	44th Stree	t		10f. Zip Code 9803	4	1	10g. Citizen of What Country?  USA			
or items must be	11. Marital Status  1 X Never Married 2 M		edent Ever in U.s orces? 2 X No	If Ye		anic Origin? ( Mexican, Puer			- American Indian, Black e, etc. white		
.0036 within 72 hours after giene her than "natural".  2. Medical Examiner ompleted by a	15. Decedent's Education (Spe Elementary/Secondary (0-12)	l or Dates: ecify only highest grad	de completed)	16a Decedent's	s Usual Occupationst of working life	n (Give kind o	f work done	16b Kind of Bus			
21215-0036 uld be filed within 72 Mental Hygiene marked other than e event, the Medical FO Be Comple		4+		n/a				n/a	a		
5-0 led w Hygin Intel	17. Father's Name (First, Middle	, Last)			1		ne (First, Middle, I	· ·			
121 I be fil ental I arked vent.	Otto Brask						Rasmusse				
D 21 should and Me is ma attice of To	19a. Informant's Name/Relations							nber, City or Towr	n, State, Zip Code)		
MD and 2 sho alth and 2 is 27 is raumati	Otto Brask - 1 20a. Method of Disposition	Father	20b F		ON.E.		Street Date	20c Location -	City or Town, State		
or He	1 Burial 2 X Cremation	n 3 Removal fr		crematory or other		Citory,	<i>D</i> 410	Zoc. Escation -	ony or rown, orace		
imor Pages ment of tant: If or othe	4 Donation 5 Other S		Me	tro Cre	natory_	Dec	2. 10, 07	Baltin	more, MD		
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med To Be Comp	21. Signature of Funeral Service	Licensee	-1	Cre	eme and Address	of Facility Society	of Mary ad Baltin	land, I	nç.		
	23a. Part I. Enter the disease, or	CON JOC	aused the death	Do not enter the	Freder	ick Roa	ad Baltin	nore, MD	21228 art Approximate Interval		
Physician /Medical Examiner	failure List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line. e a. Narcot	ic (morphi	ine) intox		acir as carata	or respiratory arr	ost, stibot, of fice	Between Onset and Death		
·	Sequentially list conditions,	b	a consequence of								
nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		consequence of	1}.							
cuted and transit	events resulting in death) Last	Due to (or as a	consequence of	f):							
760, icate be executed the burial - transi	X UNPENDED	AMENDED			ME, g863/	1/26/07	TT				
<b>∞</b> ≒ ⊕ ≤ <b>□</b>	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?  1  Yes 2  No 9  ✓ Ur	he 1 Live b	nant at time of de	2 Feta	al death 3 er (Specify)	Ectopic preg	nancy	23d Date of Month	delivery Day Year		
D. Be tr the de by the ached f	Part II. Other significant condi	tions contributing to	o death but not re	esulting in the ur	nderlying cause gi	ven in Part I	23e Did to	obacco use contri	bute to the cause of death?		
Records, P.O. The law requires that the ficate has been signed by the spee 2 should be detacht Completed by PI							1 Ye	s 2 🗸 No 3	Probably 4 Unknown		
ords or requ as been s should							24a Was autop	osy p	Vere autopsy findings available prior to completion of cause of		
Rec The la cate h							1 Yes		leath?  Yes 2 No		
tal Recician: The certificate ecetor, page	25. Was case referred to medici examiner?					of Death (Chec					
FVid Physic ruthis aldir	1 ✓ Yes 2 No		Inpatient 2	ER/Outpatient				Residence 6			
fing Ph After t funeral	27. Manner of Death  1 Natural 5 Death		e of Injury n, Day,Year)	28b. Time of In		at Work?		how injury occurre			
Sior Meath death ctor:	J Fel	0119011011		Fnd 1:30	pm I				narcotic (morphine)		
Division of Vital Records, Hospital or Attending Physician: The law requir. 24 hours after death. Funeral Director: After this certificate has been strety filled in by the funeral director, page 2 should ball Certification: To Be Completed	4 Homicide dete	uld not be ermined (Specify)		ome, farm, stree n hotel ro	t, factory, office bi	uilding, etc.	or Town, S	Street and Number State) 16001 e. MD	er or Rural Route Number, City Shady Grove Road		
Division of Vital Records, P.O. Box 6: To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a Medical Certification: To Be Completed by Physicia		Physician: To the beaminer: On the basis	of examination a								
- 5 - 0 E	29b. Signature and title of certif		11.	9	29c. License				ed (Month, Day, Year)		
	STU	My	1	1	0.0.1	/I. C.		January 5,	2007		
	30. Name and address of perso Susan Hogan MD.	Assistant Medic	cal Examiner	111 Penr	n Street, Balti	more, MD 2	21201				
State Registra		32. R	egistrar's Signatu	ure	add a						
DHMH 17 Rev 1/2001	JAIR	2001	STATE OF	ORIGINAL	- Color						

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 18, 2007 12:05A M Gayle Frank Billings /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Saint Joseph Medical Center Towson if Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Oct 21, 216-38-3221 65 1941 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MD Baltimore Director Kingsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11407 Belair Road 21087 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: white Completed by 3 Widowed 4 NDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 0 disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Franklin Billings Virginia Cecille Vaught ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Beall/niece 14740 Bonair Road Glen Rock, PA 17327 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Ronald S. Wade irector 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Baltimore, MD 21201 Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 5 ☐ Other (specify) 4□Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by CHRONIC OBSTRUCTIVE PULMONARY DISEASE 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ▼ No DIABETES MELLITUS TYPE TWO 24a. Was an 1□ Yes 2 **N**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 X Natural 2 ☐ Accident Date of injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending 1 Yes 2 No investigation within 24 hours after death. To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

and manner stated.

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32. Registrar's Signature

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Medical

29a. Certifie

(Check only one)

29b. Signature and title of certifier

BOON POH LIM.

JAN 2 5 2007

31. Date filed (Month, Day, Year)

OSLER DRIVE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D37254

Year

29d. Date signed (Month, Day, Year)

TOWSON, MARYLAND 21204

07

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** BUSICK MILDRED E. 20. 2007 8:10 AM January /Medical 4b. City. Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner St. Joseph's Nursing Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** 1 □ M 2 X F Yrs. 93 July 4, 1913 Maryland Director 217-22-0208 Usuel Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or here some any injury or other traumati 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Baltimore Catonsville Funeral Director 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 1222 Tugwell Drive 21228 **USA** 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Specify: Completed by If Yes, Give Year or Detes: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Assembly Worker Factory 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Carie (maiden unknown) George Dowell 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 1207 River Road Linthicum, MD. 21090 Edward Schultheis, executor 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBuriel 2 ☐ Cremation 3 ☐ Removal from State 01-22-07 Baltimore, MD Loudon Park Cemetery 4 Donetion 5 Dother (Specify) 22. Name end Address of Facility
Ambrose Funeral Home, Inc. 21. Signature of Funerel Service Licensee <del>132</del>8 Sulphur Spring Rd. Arbutus, MD. 23a. Far1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** e. Acute Myo concluse Frenching
Due to (or as e consequence of): Immediate Cause (Final disease or condition resulting in death) m /Medical - Aallinger Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest use es the bunal-tren Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? To the Hospital or Attanding Physician: The law requires that the de within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funerel director, page 2 should be detached it. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ğ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No edical Certification: To 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 1 Naturel 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier who completed cause of deeth (Item 23a) (Type, Print) 405 Bekler all Juke 100 CAmbrel MD 21728 30. Name end eddress of person ruh

State Registrar

DHMH 16 Rev 6/95

JAN 2 5 2007

31. Dete filed (Month, Day, Year)



ORIGINAL

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Director 10e.

Be Completed by Funeral

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Be Completed by Physician/Medical

Medical Certification: To

**Physician** /Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at aprice.

Physician /Medical Examiner

State Registrer			C	ertifica	ite of	Death			Reg	. No. 🤈	007		195
Decedent's Name (First, Middle	, Last)								ite of Death	Davis	007	3. Tii	ne of Death
Frank R.	Bonner									, 200	7 Year	11	:00 AM
Facility Name (If not institution	, give street and nur	mber)		1		r Location o	of Death				unty of Deat		
Stella Maris					Timor					Bal	timore		
Social Security Number	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yi	rs. last birthda Yrs.	Months	er 1 Year s Days	If Under Hours	Min.	8. Da	te of Birth o <i>nth, Day</i> , 1	(8 <sup>2</sup> 4)1			tate or Foreig .vania
174-05-5033								o u	-7 '/'		10.	1110/1	- Variata
a. State 10b. County		10c.	City, Town or	_ocation									de City Limits
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e. Street and Number				10f. Z	Zip Code				10	g. Citizen	of What Co	untry?	
123 Glenmoore	Avenue					21030					Un	ited	States
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Father's Name (First, Middle,	Last)					18. Mothe	r's Name	e (First	, Middle, Mi	aiden Sur	rname)		
James Bonner						Al	ice	Не	aly				
a. Informant's Name/Relations				-						-	own, State, Z	,	
John P. Bonner	. Son		1 1 2 2	Clon	maarc	Δτιων	1110	Coc		1 I I I	. MT 1	21030	
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within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division

3

State Registrar

DR. TARIQ MAHMOOD

JAN 25

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

			Please  1 - State Registrar	State of Maryland	d / Depa		lealth and M	lental Hygi	•	)7 01857
	Physici /Medic		1. Decedent's Name (First, Middle, Las Margaret Jane	Brennan				2. Date of Death Month Jan	Day	Year To 7 5. 30 A M
	Examir		4a. Fecility Name (If not institution, give 8010, Catherine	Avenue (Rose	Ganden)	PASADE			4c. County	Arundel
	Funeral Director		5. Social Security Number 6. Social Security Number 160-05-1050  Usuel Residence of Decedent	ex 7. Age (In yrs. Age 94	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 06/25/1		Birthplace (State or Foreign Country)     MD
	r 28s-f show	ector	10a. State 10b. County  MD Queen A  10e. Street and Number		Town or Loc		ensville	10	Og. Citizen of V	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Ę	death with	Funeral Director	400 Elm Street  11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. V		21666 ispanic Origin? (Span, Mexican, Puerto		14. Race	USA e - American Indian, k, White, etc.
Bremn ar 1215-0036	72 hours after "naturel", or ite	by	1 ☐ Never Married 2 ☐ Married  ③☐Widowed 4 ☐ Divorced  15. Decedent's Ed	1 ☐ Yes ŽŽXNo If Yes, Give Year or Dates:	16a Deced	Yes 21 No	Specify:	1	Specify	
- 4	c * •	Completed	(Specify only highest gra	College (1-4or 5+)	(Give ) life. D	kind of work done OO NOT use retired Account	during most of work	ing		Business
angonet,	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Market the Mental control of the Market the Mar	To Be (	17. Father's Name (First, Middle, Last) Francis Allen				18. Mother's Name	hine		
Nano	s 1 and of Health Item 27 other tr		19a. Informant's Name/Relationship (7 Mr. Kevin J. Bren 20a. Method of Disposition	nnan / son	400	Elm Str Sition (Name of latory or other place	1	vensvill	e, Mar	State, Zip Code  
Mangaret	permit. Page Depertment of Important: If eny Injury or ance.		1 Burial 2 Commation 3 4 Donation 5 Other (Specify	Ches	sapeak 22.	e Cremat	ion 01/2	ingleton	Funera	sville, MD
	Pnysician	l v	23a. Part1. Extentine disease, or composition of the composition of th	one cause on each line.	Do not ente	r the mode of dyin	- 4	or respiratory arre		MD 21061  Approximate Interval Between Onset and Death
68760,	Examiner  shysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque  Due to (or as a conseque  C. Due to (or as a conseque  d.	ence or): U	Artery	Failur	•		Xans
P.O. Box 6	w requires that the death certificate been signed by the ettending phys should be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery hth Day Year
ords, P.	equires that en signed by	þ	Part II. Other significant conditions of	entributing to death but not result	ting in the un	derlying cause give	en in Part I.			ibute to the cause of death?  3 Probably 4 Ponknown
al Reco	> 10 10	Completed	Chaonic Ron	ral failure		·		24a. Was an autopsy perform	ed? d	Vere autopsy findings available from to completion of cause of eath?
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 bounts elia doath. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2.	Certification; To Be	25. Was case referred to medical examiner?  1							
Div	ospital or A hours eftar unerel Direc ly filled in by		4 Homicide determined  29a. Certifier 1 Certifying Physics Check Carls 1 Certifying Physics 1	28e. Place of Injury - At hom building, etc. (Specify)	ledge death	occurred at the tim	ne date and place :	City or Town,	State)	er or Rural Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	iner: On the basis of examination and manner stated.	on and/or inve	29c. License				(Month, Day, Year)
			30. Name and address of person who d			rint)	54292		1 23	2007
	3 Sta Registr	te ar	SUKHPAL JASSI, 31. Date filed (Month, Day, Year) JAN 2 5 200	32. Registrar's Signatu	y Sui	h 610, C	Ion Burn	ic MT	210	<b>(</b> )

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 _ State	Maryland / De	epartment of F Certificate of		, ,		
125		ia.	Registrar  1. Decedent's Name (First, Middle, Last)		ortinoato or i	Douth	Reg. 2. Date of Death	2007	3: Time of Death
	ysicia		Russell J.	Brittian	Jr.		Tanuary	Pay 200	2 8:45AM.
	dedic amin		4a. Facility Name (If not institution, give street and num			Location of Death	1	4c. County of Deat	
4.		<b>&gt;</b> _		year Cartea		mme		Anne An	indel
Fun			5. Social Security Number 6. <b>S</b> ex 1	7. Age (În yrs. last birthd 80 Yrs	Months Days	If Under 24 Firs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Co	hplace (State or Foreign untry)
Direc	27.00		Usual Residence of Decedent	80			Nov.25, 1	926	MD
yland	at		10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
e Ma	tified	ctor	MD Anne Arundel	Glen B	Urnie				1 ☐ Yes 2 XNo
ith th	ou ac	Dire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry?
sath w	nust	sral	305 Lionsheart Glen	de la Constitución de la Constit	21061			U.S.A. 14. Race - Ame	riona Indian
Datifiniore, Intaryiatio 41413-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	xaminer	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decet Armed For 12/Yes If Yes, Give Year or Da	2 □ No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)	Black, White	
L I 3-UN thin 72 hou le. an "natura	Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-	(G	ecedent's Usual Occup live kind of work done of le. DO NOT use retired	ation during most of work f)	ing 16t	o. Kind of Business/	Industry
A l ed wij ygien ygien	t, the	Co	12	Ins	urance Sale			Insuran	ce
d be file	even	Be	17. Father's Name (First, Middle, Last) Russell J. Brittian Sr.				e (First, Middle, Mai	den Surname)	
y y lo hould d Mer marke	natic	٩	19a. Informant's Name/Relationship (Type. Print)	10b M	ailing Address (Street	Rose Sn	<u> </u>	its on Town Chats	7 Cardal
MC SI	traur		Jacqueline Brittian/ Wife	I	5 Lionshear				
ren 2	other	1	20a. Method of Disposition	20b. Place of Di	isposition (Name of		Date 20d	E. Location - City or	
Pages ent of	ry or		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	tate	crematory or other plac eake Cremat	, ,	n. 23, 007 Si	tevensvil	le. MD
Dartino Dermit, Pages Department of mportant: If it	any inju once.		21. Signature of Funeral Service Licensee	1	22. Name and Addres	ss of Facility Si	ngleton Fi	uneral Ho	me. P.A.
0 88E	등 의	_		MO1459	1 Second A	venue SW	Glen Buri	nie, MD 2	1061
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not line.	enter the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Physic /Medi			Immediate Cause (Final disease or condition resulting in death)	epsis					
Exami	2 4			r as a consequence of):					
4/5		Jer	Sequentially list conditions, if any, leading to immediate  Due to (conditions)	or as a consequence of):					
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ox o n certifii anding p	se as	•	IF FEMALE: 23c, if yes, outc	ome pf pregnancy				00d Data of dall	
death	d for u	Physician/M	in the past 12 months?	th 2 Fetal death int at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	·		23d. Date of deli Month	Day Year
by the	ache	hys	9 ☐ Unknown 9 ☐ Unknown	wn					
es tha	oe dei	و م	Part II. Other significant conditions contributing to dea	ath but not resulting in th	e underlying cause give	en in Part I.	23e, Did tobac	co use contribute to	the cause of death?
v requires been signed	plno	ed					1 Tes	2 No 3 Pr	obably 4 Dunknown
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	page 2 sh	Completed					24a. Was an autopsy performer 1□ Yes 21	prior to o	topsy findings available completion of cause of
clan:	ector,	Be (	25. Was case referred to medical examiner?		Loui		(Check only one)		
Physi this	al dire	ဥ		patient 2 ER/Outpa		4 □ Nursing Ho	me 5 Residence		cify)
tending leath.	funer	ion:	1 Natural 5 Pending (Month	f Injury 28b. Tim , <i>Day Year)</i> Inju	ry Worl	yat ⟨? Yes 2 □ No	28d. Describe how i	njury occurred	
Atten death death cctor:	y the	ficat	3 Suicide 6 Could not be determined 28e. Place of	 of injury - At home, farm,			28f. Location (Street	t and Number or Ru	ral Route Number.
al or after	d in b	Certification:	4 ☐ Homicide determined buildin	g, etc. (Specify)			City or Town, S	tate)	
ne Hospita 1 24 hours ne Funera	oletely fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the la 2 Medical Examiner: On the ba and manner	sis of examination and/o	eath occurred at the tir or investigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To th within To th	com	ž	29b. Signature and title of certifier		29c. License	e number	29d.	Date signed (Month	n, Day, Year)
/			n	<b>1</b> 0	D4	3977	J	man 19	2007.
Ø			30 Name and address of person who completed cause	of death (Item 23a) (Typ	pe, Print)	mme .	ms. 21	nb1.	
- 10G	Sta		31. Date filed (Month, Day, Year) 32 Re	gietrar's Signature	AP - NB a				
Re	gistra	ar	JAN 2 5 2007	Copper St. A.	MARIN				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day 22 Physician Month JANUARY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAL HOSPITAL OF BALTIMORE BALTIMORE 8. Date of Birth
(Month, Day, Year)

July 27, 1939 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 6. Sex **Funeral** 724 1 M 2 KF Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director JUAN STA timore 10e. Street and Number 10g. Citizen of What Country? ource "natural", or items 23a by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 ☐ Divorced ac Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATIENT Important: If item 27 I any Injury or other tra Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State awn Cemetory

22. Name and Address of Collity

Joseph L. Ruse Wood 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Funeral Ave. W. North 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) A CUTE MYOCARDIAL INFARCTION Physician DAY /Medical Due to (or as a consequence of): Examiner 2 DAYS ACUTE RENAL FAILURE Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit MONTHS MALNUTRITION Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical EAR ESOPHAGRAL use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by LUNG CANCER 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate 25. Was case referred to medical examiner? To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 1 Natural 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 22,2007 D0060600 30. Name and address of person who comp cause of death (Item 23a) (Type, Print) SINAL HOSPITAL OF BALTIMORE SKAR WD YNNE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 5 1150

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health a  1- State Registrer Certificate of Death			( U U	7	01850
			1. Decedent's Name (First, Middle, Last)	-	Re 2. Date of Death	g. No.		3. Time of Death
	Physici		Annie Ruth Cheatham		Month	Day 18	Year 07	0443AM
	/Medic Examin		4e. Facility Name (If not institution, give street and number)  4b. City, Town, or Location	of Death	<u> </u>	4c. County	of Death	
			Hopkins Elder Plus Edgema			Da	1171	nore
	Funeral		Months Dave Hours	Min.	B. Date of Birth (Month) Day,	Year)	9. Birthp Coul	place (State or Foreign ntry)
	Director		213-14-8225 1 M 2004 94 Yrs. Worlds 233 Tools		01/01	11912	/	vC
	yland		10a. State 10b. County 10c. City, Town or Location				1	0d. Inside City Limits
	h the Marylan r 28a-f show s notified at	ctor	MD Baltimone Dundalk					1 Yes 2 No
	with th	Director	10e. Street and Number		10	g. Citizen of V		ntry?
	eath v	erai	521 New P.Hsbvrs Ave 21222  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or	rigin? (Soon	ify Voc or No		LSA	can Indian,
	after dea or items	Funerai	Armed Forces? If Yes, specify Cuban, Mexical		ican, etc.)		k, White,	
	O36	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	<i>/</i> :		Specify	B	K
	15-003	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during mos	st of working	7	6b. Kind of Bu	ısiness/In	dustry
	within the the	duic	Elementary/Secondary (0-12)  College (1-4or 5+)  Waitre>	s		Food	See	evice
	and 212' be filed within that Hygiene of other than event, the M				First, Middle, M	<u> </u>		
	# \$ 5 5 5 e	To Be	Eli Tillman Ca	allie	- Lo	mas	K	
	Maryla d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print) Ldaushkr) 19b. Mailing Address (Street and Numb	per or Rural	Route Number,	City or Town,		
	ore, M		Phyllis R. Seawell 523 main St. T.				2127	
	Pages 1 nent of H ant: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Da		Oc. Location -		
	Baltimol permit. Pages Department of Important: If is any injury or o		'4 □ Donation 5 □ Other (Specify) Meadow Ridge  21. Signature of Funeral Service Licersee 22. Name and Address of Facilities	1/23	101	EIKr	dge	MUSH
	Balti permit. Departr Imports any inju	W g	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licentsee  Vaysh C  S151 Balto	Nat	12 P.K.	e Ba	Ho.	MD. 21229
۲			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	s cardiac or	respiratory arres	st,		Approximate Interval Between
Z	Priysician		Immediate Cause (Final disease or condition				4	Onset and Death
in	/Medical Examiner		resulting in death)  Du tu(r as a consequence of):					Days
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$\circ$	68760, cate be executed physician and the burial-transit	dicai	d					
۲	x 68 entific	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		-			
L	Box 6 death certific	ian	in the past 12 months?			23d. Dat Mo	e of delive ath	ery Day Year
. 2	P.O. I	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (speciny)	·				
(=	Records, P.O. Box 6  The law requires thet the death certif  te has been signed by the attending  page 2 should be detached for use as	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		23e. Did toba	acco use conti	ribute to th	ne cause of death?
21	cords w require been sig	edt	_ COPD, CHF OSTED ARTHRITY	~	1 🗆 Yes	2 □ No	3 🗌 Prob	ably 4 Unknown
. ~	of Vital Record Physician: The law requir this certificate has been si	Completed			24a. Was an autopsy	24b. \	Vere auto	psy findings available npletion of cause of
Z Z	The The cate h	Con			perform 1 ☐ Yes 2	ed?/	leath?	
7	of Vital Rec Physician: The law this certificate has brail director, page 2 s	Be	examiner?	/	Check only one			
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	ion nding ath. r: Afte e fune	atior	1	1				
	Division or Attending after death. Director: After In by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	f. Location (Stre City or Town,		er or Rura	l Route Number,
B	Distance of the state of the st							
S	Division of To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier  (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge, death occurred at the time, date an 2 ☐ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, dea and manner stated.	nd place, an ath occurred	d due to the cau at the time, dat	use(s) and ma e and place, a	nner as st and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number			d. Date signed		
			2043	83	J	anua	ry 1:	2 2007
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hz  W, B COCNOUPH MD BALT	OPKIO	ws BA	-NOIE	X) C	1 RCLE
	Sta	to	31. Date filed (Month, Day, Year)  32. Merican Signature	בוט רט	E, T	12	122	-7
	Registr		IAN 2 5 2007 Assert Is Appealed					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician CRABBE Month Day 12.33 A M N 01 2007 '/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Care Baltimore Irvington
ex 7. Age (In yrs. last birthday) ture If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 943 1 ☐ M 2 💢 F Yrs. 12 96 Director 1910 MV April Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Be Completed by Funeral Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 2503 Violet 21215 USA Ave Apt. 5135 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Elevator Operator telephone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Lownar 1-annie Berry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) aurease Kichardson Kevin 1230 Baitimore, MID daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Kock Cemeter 1/26/07 22. Name and Address of Fability
Vallynn C. Greene Funeral Services
5151 Baltimore, MAtional Pike Bo 21. Signature of Funeral Service Licensee 5151 Baito, MD 21269 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lilure. List only one cause on each line. Approximate Interval Between Onset and Death therosclerosi immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner 1000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 🕱 No 4□Pregnant at time of death Month Day 5 ☐ Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 □ No To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 0024476 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) San 50 RE M.D. 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2**007** January 6:00 A M Priscilla Mary Cooper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Crofton Convalescent & Rehab Ctr. Anne Arundel Crofton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 25, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2**X** F 82 Yrs. 023-16-6211 1924 Massachusetts Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2 No r 28a-f sh notified Directo Maryland Anne Arundel Crofton 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code "natural", or items 23a or idical Examiner must be USA 2131 Davidsonville Road 21114 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation th and Mental Hygiene.
77 is marked other than "naturaumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)  $1\widetilde{2}$ Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leslie Dempsy Nickerson Eleanor L. Swett ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr 2935 Tallow Lane Bowie, Maryland 20715 Tamara Kaye, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/24/07 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Lansee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athroschotic Cardiovasculas Diseasc **Physician** /Medical therosolerotic Cerebro Vascular Dis pur Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed nin 24 hours after death. physician and s the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. has been signed by the e 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate har funeral director, page 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death | Director: A | d in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year)

Registrar

n

Rakesh Arora,

31. Date filed (Month, Day, Year)

M.D. 14300 Gallant Fox Lane Suite 222 Bowie, MD 20715

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2007

82. Registrar's Signature

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	_		1 - For State Registrar	State of Marylan	d / Depa	artment		and Me	ntal Hyg	_	07	01863
The same of the sa	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Lasi Margaret Cora 4a. Facility Name (If not institution, give	Czaska pstreet and number) NCO (	er	Bel	wn, or Location	n of Death	Date of Dea Month	gay 4c. Count Har	2007	6.30 pm
	Funeral Director		5. Social Security Number  6. Se 219-10-1448  Usual Residence of Decedent	7. Age (In yrs. I	Yrs.	If Under 1 Months	Year If Under Days Hours	er 24 Hrs. 8 Min. I	Date of Birth (Month, Day Peb. 14	(Year)	Cour	place (State or Foreign ntry) ry1and
	be filed within 72 hours after death with the Maryland ital Hygiene. ad other then "naturel", or itema 23a or 28a-f ahow avent, the Mudical Exphiner must be notified at	by Funeral Director	Maryland Harfo  10e. Street and Number  614 High Plain Dr	ord		Bel Ai	ode 21014	Drinin? (Specia				
9600	hours after di urel', or item il Exeralmen	d by Fun	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No II Yes, Give Year or Dates:		1□Yes 2	nt of Hispanic C Cuban, Mexic		can, etc.)	Spec	ack, White,	etc. nite
21215-0036	filed within 72 t Hygiene. other then "net	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th Grade	ucation de completed) College (1-4or 5+)	(Give	tent's Usual kind of work DO NOT use Buye	done during mo retired)				Retail	·
Maryland	2 should be file and Mental Hy is marked oth sumatic svant	To Be (	17. Father's Name (First, Middle, Last)  Bernard Czaska  19a. Informant's Name/Relationship (7)	ine Brief (hrother-	- 10h Mailie	an Address (		Cora (	Gerstle			Codel
	1 and Health am 27 ther tr		Walter A. Wolfel 20a. Method of Disposition	, Jr. in-law)		High I	lain Di		Bel Air		land	21014
Baltimore,	permit. Pages Department of importent: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licents)	) Ba		. Name and	Address of Fac		nunek I	Tuneral	Home	Maryland of Bel Aii d. 21014
)	Physician /Medical		23a. Part f. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence)	13	er the mode	ol dying, such a	as cardiac or r	respirato <i>r</i> y arr	rest,		Approximate Interval Between Onset and Death
760, <	Examiner	ical Examiner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a conse	uence olj:							
P.O. Box 68	the d	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	Ectopic preg Other (spec				1	ate of deliver	ery Day Year
rds, P.	w requires thet the been signed by should be detac	by	Part II. Other significant conditions co			nderlying cau	se given in Par	t I.	23e. Did to	,	ntribute to th	ne cause of death?
of Vital Records,	i: The law ri icate has be i, page 2 shi	Completed							24a. Was a autops perform	an 24b sy med? 2 1 No	Were auto prior to code death? 1 \( \text{Yes}	psy findings available mpletion of cause of 2 No
ion of Vit	To the Hospital or Attending Physicien: The within 24 hours elter death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation; To Be	25. Was case referred to medical examiner?  1	Hospital: 1   Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		! Other	28	5 ☐ Resid	ne) ence 6 □Ol ow inju <b>r</b> y occu		y)
Division	To the Hospital or Attending within 24 hours effer death.  To the Funeral Director: Affer completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, lactory,	office	28	I. Location (S City or Tow	treet and Nurr n, State)	ber or Rura	il Route Number,
	the Hospi in 24 hou the Funer prietely fill	Medicai	(Check only 2 Madical Exam	ysician: To the best of my kno inar: On the basis of examina and manner stated.	wledge, death tion and/or in	vestigation, in	n my opinion, de	eath occurred	at the time, d	date and place	, and due to	the cause(s)
	To T com	2	29b. Signature and title of certifier	MD		_	icense numbe			Junuur		
	le			w111 2 Nov	th A	Print) VINU(	Bil	Die	Mar	gland	210	2007
3	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	A. A.	20.000						

DHMH 17 Rev 1/2001

07-00275 Raymond Carr

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 01864

		I-For State Ce	ertificate of	Death		Reg	j. No.	
Physicia		Decedent's Name (First, Middle,Last)		-		<ul> <li>Date of Death Month</li> </ul>	Day Year	3. Time of Death
ledical Examin	er	Raymond Carr				January 10	, 2007	0358 hrs
	4	4a. Facility Name (if not institution, give street and number)	4	1b. City, Town, or Lo	ocation of Death		4c. County of Deat	th
)		University Shock Trauma		Baltimore				
Funeral		o, occiai cocain, i i i i i	last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9 Bi Forei	
Director		unk   1x M 2 F 46	Yrs	Months Days	Hours Min.	Aug 5,		ign unk ountry)
	-	Usual Residence of Decedent		1		146 5,		
á		10a. State 10b. County 10c. Ci	ty, Town or Locati	on				10d. Inside City Limits
		unk unk					unk	1 Yes 2 No
Aaryland 28a-f show any 1 at once.	핡	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	untry?
Mar r 28a	Director	Toe. Street and Number	unk	,	un	k		unk
			11.0 T40 W	Decedes of History	ania Osining / Sun	eifu Vac or No	14 Paga Ame	rican Indian, Black,
h wil	era Lec	11. Marital Status 1 Never Married 2 Married Armed Forces?		s Decedent of Hispa es, specify Cuban, I			White, etc.	incarr inclari, black,
or its	Funeral	1 Yes 2 No		· · · · · · · · · · · · · · · · · · ·			Canadia 1	11-
	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X No			Specify: 16b. Kind of Business	lack
5-0036 led within 72 hours after Hygiene "natural", the Medical Examiner		15. Decedent's Education (Specify only highest grade completed)	during m	nt's Usual Occupation ost of working life. [	DO NOT use retire	d) unk	TOD. KING OF BUSINESS	unk
36 hin 72 l te than "l edical F	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)						GIII.
003 within ene er th	Ĕ	unk unk		146	8.Mother's Name (	First Middle M	laidae Surnama)	
5-00; iled with Hygiene I other ti		17. Father's Name (First, Middle, Last)		unk	b.Mother's Name (	riisi, iviidale, iv	laideir Surriame)	unk
21215-0036 and be filed within 7 Mental Hygiene marked other than c event, the Medica	a		1401-140-1-	- 4	and North and Br	and Davido Nive	ber, City or Town, Sta	to Zin Cada)
ID 21215-0036 should be filed within and Mental Hygiene T is marked other than natic event, the Media	ို	19a. Informant's Name/Relationship (Type, Print )		•				te, Zip Gode)
MD id 2 sho ilth and m 27 is	-	O.C.M.E.		Penn Stre		more, M	20c. Location - City of	or Town State
nore, MD 2 gges 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic	- 1	20a. Method of Disposition 20 1 Burial 2 Cremation 3 Removal from State	crematory or ot		letery,	Date	200. Eddallon Only	or rewin otate
Pages nent of ant: If or othe		4 Donation 5 X Other Specify: in state						
Baltimore, permit Pages 1 a Department of He Important: If ite	1	21. se dure of peral price lic. Direct	or 22,1	Name and Address	of Facility	655 W	Baltimore	Street
E P P P P P P P P P P P P P P P P P P P	- 1	Men Alla III	Ba	ltimore,	MD 21201			- Street
Physician	7	23a. Part I. Enter the disease, or complications that caused the de	ath. Do not enter t	the mode of dying, s	such as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical		failure List only one cause on each line.  Immediate Cause (Final disease a. Teumonia compl	icated by	hypothermia	a			Death
Examiner	- 1	Immed te Cause (Final disease or condition resulting in death)  a. Teumonia Compt		-91	-			
Marie of State of Sta	- 1	Convertibility lost goodiffices b.						
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	e of):					
	힐	cause. Enter Underlying Cause (Disease or injury that initiated						
ed sit	Examiner	events resulting in death) Last  Due to (or as a consequence)	e or).					
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8760, tificate be ng physic as the bur	Š	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of p		etal death 3	Ectopic pregnar	ncv	23d. Date of deliver	Day Year
		past 12 months?  4 Pregnant at time of	f dooth	other (Specify)		1		
Box 687 he death certific y the attending p	Physicia	1 Yes 2 No 9 Unknown 9 Unknown						
Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed rail bircetor. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial—transit		Part II. Other significant conditions contributing to death but n	ot resulting in the	underlying cause gi	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
P.(	by					1 Yes	2 No 3 P	robably 4 🗸 Unknown
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Re( The icate	Ö					1 Yes	2 No 1 🗸	Yes 2 No
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n of ing P		27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of		res 2 X No	exposure	to cold envi	ronmental
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pital Di	Sert	4 Homicide determined (Specify) four	nd on stre	et		altimore	e, MD	
Hospita 24 hours Funeral	<u>e</u>	29a. Certifier 1 Certifying Physician: To the best of my know	vledge, death occ	urred at the time, da	ate and place, and	due to the caus	se(s) and manner as s	tated.
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical Certification:	(Check only one) 2 Medical Examiner: On the basis of examinati and manner stated.	on and/or investig	ation, in my opinion	n, death occurred a	it the time, date	and place, and due to	ine cause(s)
L × L ×	Me	29b. Signature and title of certifier		29c Licens	e number		29d Date signed (i	Month, Day, Year)
		Carol HAR Od	(	0.C.I	M.E.		January 10, 20	007
		30. Name and address of person who completed cause of death	Item 23a)				- 7	
		Carol Allan, MD Assistant Medical Examine		Street, Baltime	ore, MD 2120	1		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Sig	gnature					
Regis		R.V	H. hora	19.5				
DHMH 17 Rev 1/2		JAN L 3 COOL JOGGEROOF J	ORIGIN	Δ1				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year aM anuary William Downs 24, 2007 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Taryland Garreral 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 22, 19 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours 1 M 2 F Days 65 Director 214-40-6792 1941 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 ☐ Yes 2 ☐ No MD Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1100 Pennsylvania Ave. Zion Towers USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Black **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Disabled n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ William F. Downs Daisy Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Tucker - Sister <u>661 Queensgate Road Baltimore, MD 21229</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 又Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Jan. 25, 07 Baltimore, MD 21. Signature of Funeral Service Licenses <sup>22</sup> Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Immediate Cause (Final disease or condition resulting in death) neumona **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 NO 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Iniurv death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Records, P.O. Box 68760, Division or Vital

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by completely

> m State

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

5

29b. Signature and title of certifier

MD

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint)

and manner stated.

Tavadi

32. Registrar's Signature

			1 - For Amend Item	s 23a,Pt1,	Maryland / [ TI,25 per	Depa <i>Cer</i>	rtmen <b>C86</b> 3 tificate	91 H	ealth á Death	7dhb	lental Hy	giene	007	01866	
~	Physicia	an	1. Decedent's Name (First, Middle			mtt	DODD	, III			2. Date of De Month	ath Day	Yea	3. Time of Death	
	/Medic	al			ELIZABE	.I.H			1	( D 1)	JAN.	13,	2007		
	Examin	er	4a. Facility Name (If not institution						Location of				County of De		
	* Funeral	70	CARROLL HOSP 5. Social Security Number		'. Age (In yrs. last bir	rthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th	9. 8	Birthplace (State or Foreign	
ь	Director		214-32-4966	1□M 2√ F	79	Yrs.	Months	Days	Hours	Min.	(Month, Da 6 / 2 4 / 1			Country) ARYLAND	
	Du *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	cation						-	10d. Inside City Limits	
	Aaryla F sho	ō		ROLL			MINS	TER						1 □Yes 2 No	
	28a-	Director	10e. Street and Number	ROLL			10f. Zip					10g. Citi	zen of What	of What Country?	
	h with		2036 NICODEN	MIS RD				211!	57			US	SA		
	ems :	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S.	13. V	Vas Deced	dent of Hi	spanic Ori n, Mexicar	igin? (Sp	ecify Yes or No Rican, etc.)	)-	14. Race - Al Black, W	merican Indian, hite, etc.	
36	within 72 hours after deeth with the Maryland ene. Itan "natural", or items 23a or 28a-f show he Medical Examinar nast be notified a	by Fu	1 ☐ Never Married 2 Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			I □ Yes						Specify: W.	нтте	
21215-0036	72 hours "natural", dical Exe			Year or Dat		. Deced	ient's Usua	al Occupa	ation			16b. Ki	ind of Busine		
215	nin 72 In "ns	Completed	(Specify only highe: Elementary/Secondary (0-12)	st grade completed)  College (1-	4or 5+)	(Give I life. D	kind of wor DO NOT us	rk done d se retired	during mos ()	t of work	ing				
212	filed within Hygiene. Ither then ont, the Mi	Com	11	Comogo (1	40.07)		Dai	ry	Far				cicul	ture	
pu	d ta b	Be	17. Father's Name (First, Middle,	Last) HARLES RI	DGELY					er's Name HELI	e (First, Middle		Sumame) MITT		
Maryland	should be file and Mental Hy marked oth umatic event	은	19a. Informant's Name/Relations			Mailin	a Addrass	/Street			al Route Numb			a Zin Code)	
Ma	id 2 sho ith and 27 is ma		HENRY L. DOD!		BAND 20		-					-		MD 21157	
ē,	s 1 and if Health item 27 other to		20a. Method of Disposition		20b. Place o	f Dispos		ne of			7/07			or Town, State	
E	Pages nent of int: if it		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		EVERGRI	-	-			ARDI	ENS	FINE	KSBUR	G, MD	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Juperal Service	Licensee										HOME, P.A. MD 21157	
	āK.		23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.											Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	-a Pne	cumonia									Onset and Death	
	/Medical Examiner		resulting in death)	Due to (d	or as a consequence	of):	-	11	î -	1					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (c	Pira hon as a consequence	of):	tee	41	1.90	icls	- /	1			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	End	Stage Al	zhei	imer'	s De	menti	ia	11	/	WER		
o,	te be executed ysicien and ne burial-transit		resulting in death) Last	Due to (c	or as a consequence	of):				14	PROVED ENTE	MCAL =			
8760	a × a	lical		d					-71	101	PROVIDE				
× 68	ding p	/Mec	IF FEMALE:	23c If yes outc	ome of pregnancy		-		CENTR	Blo				detiren	
Вох	leath certificat attending phy I for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 ☐ Fetal death ant at time of death		Ectopic pr Other (sp		·	1:			23d. Date of Month	Day Year	
P.O.	the d y the ached	ysi	1 □ Yes 2 🔼 No 9 □ Unknown	9□ Unkno											
	ires that the death signed by the atte d be detached for	y Pi	Part II. Dther significant condition	ons contributing to dea	ath but not resulting i	in the ur	nderlying c	ause giv	en in Part I	١.	23e. Did	obacco i	use contribute	e to the cause of death?	
ıd	w require been sig should b	ted t	End styre	Alzheine	r's der	1200	hier				1 🗆	Yes 2	<b>∆</b> No 3□	Probably 4 Unknown	
Records,	The la ate has page 2	Completed by									24a. Was auto perfo 1  Yes		prior		
Vital	Physician: this certificant	Be	25. Was case referred to medica examiner?	Hospital:				0#		e of Deat	h (Check only	one)			
of	Physic this crat direct	- To	1 XYes 22 No  27. Manner of Death	28a. Date o	patient 2 ER/O	utpatien Time of			4 🗆 141		me 5 Res			(pecify)	
O	Jing After fune	tion	1 Natural 5 ☐ Pendir	/A do nth	n, Day Year)	Injury	м	28c. Injun Worl 1 □	k? Yes 2 □		200. 2030/120	11044 11170	y occurred		
Division	Attending or death.	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At home, fa	arm, str	eet, factor	y, office						Rural Route Number,	
Θ	al or safter	Certification:	4  Homicide determ	buildin	g, etc. (Specify)						City or To	wn, State	"		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (		ng Physician: To the Examiner: On the ba and mann	sis of examination ar										
	To the To the comp	×	29b. Signature and title of certifie	) -			1		e number				-	onth, Day, Year)	
•			Daloh	marce	> 260		ł	<b>1</b> 5	5 9 3	9		1/	15-12	00 t	
			30. Name and address of person	who completed cause	of death (Item 23a); 218 Lesh		Print)	e. hl	& Mo	da	riwer	tmin	cter n	007 D 21157	
100	Sta	ate	31. Date filed (Month, Day, Year JAN 2 4 200	32. Re	egistrat's Signatore	all s	0	ン ''	4 / 14	, -, 1	J + - W	, 1, ,(	. 10 , 1	y -1(3)	
	Regist		JAN 2 4 200	J. B. M. LAR.	No Page										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ethel Marie Dodson JANUARY 2007 9:50p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6907 Windsor Mill Road Gwynn Oak Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) JUN 21, 19 Birthplace (State or Foreign Country) **Funeral** Days Hours 228-16-5787 85 1921 Virgiñia Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐XNo Baltimore Director Maryland Gwynn Oak 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 6907 Windsor Mill Road 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Retail Sales for 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Employees pp Postal Contractor Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event, it once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Dove ဂ္ <u>Arthur Napoleon Petitt</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20313 Middletown Rd. Freeland, MD 21053 David Lee Dodson/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/29/2007 4 Donation 5 ☐ Other (Specify) Eldersburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD ) awno (410-795-1400) 23a. Part1. Enter the disease, or complications that caused the d ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

JAN 2 5 2007

Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of reath (Item 23a) (Type, Print)

Both



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N. Charles St. Balts, md 2120,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23a, b, 25 per ME, G603, 01/23/07dhb
Reg. No. Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 01:10 M Jerome Fair Januar 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner medical Center 5. Social Security Number 60 Maryland Baltimore mD If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Min. 55 Director 219-52-8803 51 MD bз 07 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic even. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore NA Funeral Director MD X□Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1743 Champlain Drive Apt C 21207 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [Ž]
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: Black Specify 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Diffe Color of Safety Elementary/Secondary (0-12) College (1-4or 5+) Risk Management M.T.A. 12th grade 3yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosalee Gibson J. T. Fair ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 7115 Rudisill Ct Apt 1B, Jamila Roberts-Daughter Windsor Mill, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 1/22/07 Randallstown, Md 21. Signiture of Funeral Service License <sup>22. Name and Address of Facility</sup>
March F/H West 4300 Wabash Ave, Baltimore, Md SUM Me 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Intercranial Hennorthag disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner MON APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed for use as the burial-tra Due to (or as a consequence of). or Vital Records, P.O. Box 68760 Physician/Medical CERTIFI IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? Yes 2 No this certificate 1□ Yes or Attending Physician: Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes ZIVINO Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manney of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division 1 ☑ Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 Tes 2∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 2007

State Registrar

DHMH 17 Rev 1/2001

#23a tax to ME

Greene St.

Baltimore

22 South

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

Bennis

Himee

31. Date filed (Month, Day, Year)

JAN 2 4

	•	1 - For State Registrar	Stat	te of Maryla		artment of		-	40	07	01869
		Decedent's Name (First, Middle	a, Last)			- Inoute o	Douin	2. Date of De	Reg. No. ath		3. Time of Death
Physici		Dorothy Mari	e Full	er				Month January	Day 10,	2007	1:35 P M
/Medic Examin		4a. Fecility Name (If not institution				4b. City. Town	, or Location of Dea			ty of Death	
Exami	er	Keswick Multi					Baltimore			,	
Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Ye	ar If Under 24 Hr	s. 8. Date of Bin	th	9. Birth	nplace (State or Foreign untry)
Director		212-09-8957	1□ M 20	MF 92	Yrs.	Months Day	rs Hours Mir	Feb. 20	v. Year)	Cou	untry) (aryland
		Usual Residence of Decedent						1100. 21	, 1,11		
yland		10a. State 10b. County		10c. 0	City, Town or Lo	ocation		-			10d. Inside City Limits
Mar Feet	ţ	Maryland Pri	nce Geo	orge's		Lau	rel				1 ☐ Yes 2 ☑ No
h the	Director	10e. Street and Number				10f. Zip Code	•		10g. Citizen of	What Cou	untry?
h witt	0	8016 Patuxent	Landi	ne			0724			U. S	. A.
deat	Funerai	11. Marital Status	12. Was	s Decedent Ever in	U.S. 13.	Was Decedent of	f Hispanic Origin? (	Specify Yes or No	- 14. Ra	ce - Ameri	rican Indian,
after a	Ē	1 Never Married 2 Marr	ied 1 🗆	ned Forces? ]Yes_2[∑]No			uban, Mexican, Pue	rto Hican, etc.)	1	ack, White	, etc.
3 sun Sin	b	3 Midowed 4 ☐ Divorced	Yea	es, Give TE ar or Dates:		1□Yes 2∭ h	lo Specify:		Spec	ify: W	hite
72 hc	Completed	15. Decedent (Specify only highes	's Education	lated)	16a. Dece	dent's Usual Oct	cupation ne during most of w	orkina	16b. Kind of I	Business/Ir	ndustry
Fig. 1	g	Elementary/Secondary (0-12)		lege (1-4or 5+)	life.	DO NOT use ret	ired)	UIKHIY			
Z general	50	12th Grade				Loan	Clerk		Bar	nk	
	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's Na	ame (First, Middle,	Maiden Suma	ime)	
Wents of the control	2	William M. G	lenn				I	Mary Anna	. Vogle:	song	
Id yidilid ZIZIS-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Ie marked other than "naturel; or items 23s or 28s-f show aumatic event, the Macical Examiner must be notilled at		19a. Informant's Name/Relations	nip <i>(Type, Prir</i>	nt)	19b. Mailir	ng Address (Stre	et and Number or F	Rural Route Numbe	er, City or Town	n, State, Zi	ip Code)
partificity, Individual ATATIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23s or 28s-f show ery injury or other traumatic event, the Medical Examiner must be notified at once.		Glenn C. Fuller	r, Sr.	(son)	8016	Patuxer	t Landing	g, Laurel	, Mary	land	20724
oth if		20a. Method of Disposition	- 6-		Place of Dispo	sition (Name of	place)	Date	20c. Location	- City or T	own, State
mit. Pages pertment of portent: if it y injury or c		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (S)					·	13/2007	Baltim	ore.	Maryland
mit.		21. Signature of Funeral Service					dress of Facility Sc				
Depermine on y impo		Stapen	uo	Kina			ms Lane,				
		23a. Part1. Enter the disease, or	complications	that caused the de							Approximate
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trending death. for: Afte the fune	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be	Discontinuity At			□Yes 2□No	204 1	24		
or A	Certification:	4 Homicide determ	ined 289.	Place of Injury - At building, etc. (Spec	nome, tarm, str cify)	eet, factory, offic	e	City or Tox	otreet and Num vn, State)	ber or Hur	ral Route Number,
pitai urs a erei i	ő,	20a Carifica	- Dhyssis's	Ta tha 1							
To the Hospital or Attending Physician: The law requires that the death certify hours after death.  To the Funeral Effector. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edicai	29a. Certifier 1 Cartifyin (Check only 2 Medical	Examinar: On	To the best of my kr	iowiedge, death ation and/or in	n occurred at the vestigation, in m	time, date and place y opinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place	anner as s , and due t	stated. to the cause(s)
thin the mple	Med	29b. Signature and title of certifier		d manner stated.		29c Line	nse number		29d. Date sign	ed (Month	Day Year)
F 3 F 8		M. Tabell		A 1	1-12		3657		_		•
							500.		J anuar	y 17	7,2007
7		30. Name and address of person TSABELE V	who completed	d cause of death (Ite	m 23a) (Type,	Print)	TT. LALT				
		31. Date filed (Month, Day, Year)	11TUTK	EGOR, 700 32 Hegistrar's Sign	nature	11/10/10	- 1000	,,.	2 2.3	-,,	
Sta Registr		JAN 2 5		Janeyistiai s Sigi	Mr La	asks					

Division or Vita	Division or Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician:	To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.	
To the Funeral Director. After this certific	To the Funeral Director: After this certificate has been signed by the attending physician and

			Please						•	Are Legible.	
			For State Registrar	State of Ma	aryland		artment of F rtificate of	lealth and N <i>Death</i>	lental Hy	rgiene Reg. No. 2 A A T	7 01870
	Physicia	an	1. Decedent's Name (First, Middle, Li	ast)					2. Date of De		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, gi		) }		4h City Town o	r Location of Death	01	07 2007 4c. County of Dec	
} : .	Examin	er	Sing do	PHAL			na	timore		40. Godiny of Ber	201
	Funeral		Social Security Number 6.	Sex 7. Age	e (In yrs. las	s <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year) C	rthplace (State or Foreign country)
	Director		Usual Residence of Decedent					1	Jan. 7	7, 2007	MD
	larylan show	'n	10a. State 10b. County	11	10c. City,	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	r 28a-f notifie	Director	MD Can 10e. Street and Number	roll		Ŀ	Inksburg 10f. Zip Code			10g. Citizen of What C	
	23a or		2224 Northfield	i Court			210	· -		USA	
	ter dez Items Iner m	Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N		. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14. Race - Am Black, Wh	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Healith and Menhal Hygiene. Hen 21 sa arked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 <b>X</b> No	Specify:		Specify:	White
<u>2</u>	"natu edical	Completed	15. Decedent's E (Specify only highest g	ducation rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. Kind of Business	s/Industry
_	filed within Hygiene. Ither than "	ошо	Elementary/Secondary (0-12) N/A	College (1-4or 5	i+)	me.	N/A	<i>a</i> )		N/A	
Maryland 2	be filed Ital Hyg Id othe event,	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Name	e (First, Middle	, Maiden Surname)	
<u> </u>	should ind Men marke umatic	2	Dominic Faloni  19a. Informant's Name/Relationship	(Type, Print)		19b. Mailii	na Address (Street		ee Leis al Route Numb	hure per, City or Town, State,	Zip Code)
	and 2 sealth ar n 27 Is		Dominic Faloni	Fath	er					burg, MD 2	
altimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 [	☐Removal from State	20b. Pla	ce of Dispo	osition (Name of matory or other plac	i	Date	20c. Location - City of	
			4 □ Donation 5 □ Other (Spec 21. Signature of Puneral Service, Lice		Car		Cremation 2. Name and Addre			Hampstead	
n	permit. Departr Imports any inj		1/1/1/	Mar	in					Reisterstoerstoerstown, M	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each lir	ne.					arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SEVE	A CONSEQUE	PRE 1	LATURI	ty e 17	WILS		1 MINUTE
	Examiner		Sequentially list conditions	b							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):					
60,	be executed cian and ourial-transit		that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):					
9/89		Physician/Medical		d							
ВОХФ	n certiffi Inding   use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7=		. i	23d. Date of de	elivery
	The law requires that the death certificate te has been signed by the attending phys age 2 should be detached for use as the	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant at 9□Unknown			□Ectopic pregnancy □ Other <i>(specify)</i> _	y j	UA	Month L^	Day Year
л О	that th ed by t detach		Part II. Other significant conditions	contributing to death be	ut not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Vital Records,	w requires that the do been signed by the should be detached	ed by							1 🗆	Yes 2 No 3□F	Probably 4 □Unknown
် ပိ	e law re has be e 2 sho	Completed							24a. Was	psy prior to	utopsy findings available completion of cause of
<u>e</u>			25. Was case referred to medical					26. Place of Deat	1□ Yes	ormed? death? 2 No 1 □ Ye	s 2 10
<u> </u>	nysicia nis cert direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: Inpatie	ent 2 🗆 El	R/Outpatier	nt 3 DOA Oth	A#1		idence 6 ☐Other (Sp	ecify)
o C	ling Pl I. After ti funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ ko	28d. Describe	how injury occurred	
Division or	Attence r death ector:	Certification:	2 Accident investigation 3 Suicide 6 Could not lead to determined	oe 280 Place of init	ury - At hom	ne, farm, str	eet, factory, office		28f. Location (	Street and Number or F	Bural Route Number,
בֿ	ital or irs afte ral Dir lled in					1	1/1		City or To	NIT	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director,	Medical			f examination					cause(s) and manner a , date and place, and du	
	To th within To th comp	Me	29b. Signature and title of certifier	120			29c. Licens	e number		29d. Date signed (Mor	nth, Day, Year)
)			Margey	Kala	anth /lt · · · ·	29a) /Tr		37003		01/08/2	66'7
			30. Name and address of purson who	G KATES	eath (Item 2	Saj (Type,		HAL			
	Sta		31. Date filed (Month, Day, Year)	32. A gistra	ar's Signatu	ire.	beek				
	Registr	ar	JAN2 2	2007	40 1	7					

			Please	State of M							•	_	bie.	
			for State Registrar	Otate of M	aryianu		rtificat			aria ivi	,	Reg. No. 2	0.7	01871
			Decedent's Name (First, Middle, Last,	1						T	2. Date of De	eath	0 1	3. Time of Death
ķ.	Physicia /Medic		+ Homas	FALON	) [						Month	Day >(	Year	2030 M
Y Far-	Examin		4a. Facility Name (If not institution, give	street and number)	•		4b. City,	Town, or	Location o	of Death		4c. County	of Death	
	3 *	4		SPITAL				1 -	3411	TIME				
	Funeral		5. Social Security Number 6. Sec.	7. Ag	je (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birth	place (State or Foreign intry)
	Director		N/A Vsual Residence of Decedent			110.				9	Jan. 7	, 2007		MD
	/land ow at		10a, State 10b. County		10c. City,	Town or Lo	cation				<del></del>			10d. Inside City Limits
	Many a-f sh ified	ţċ	MD Carroll			Finks	burg							1 ☐ Yes 2 🙀 No
	th the or 28; e not	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	intry?
	23a ust b		2224 Northfield	Court				2104				USA		
	tems term	Funeral	TTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTT	12. Was Decedent Armed Forces?		13.	Was Deced if Yes, spec	lent of His city Cuba	spanic Ori n, Mexicar	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	)- 14. Rac Blac	ce - Americk, White,	can Indian, , etc.
36	s afte , or i	by F	1 MNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		1 ☐ Yes	2 <b>X</b> No	Specify:			Specif	y:	TI * .
215-0036	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dother than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		15. Decedent's Edu	cation		16a. Dece	dent's Usua	al Occupa	ntion			16b. Kind of B		White
212	in "ne Medic	Completed	(Specify only highest grad	e completed) College (1-4or l	5+)	(Give life.	kind of wor DO NOT us	rk done d se retired)	uring mosi	t of workir	ng			•
-	filed within Hygiene. Ither than "	l M	N/A	Concgo (1 Yor			N/A						N/A	
Maryland 2	should be filed nd Mental Hygi marked other imatic event, t	Be (	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	, Maiden Surnan	ne)	
<u>Xa</u>	should be and Mental s marked o umatic eve	횬	Dominic Faloni						Aime	ee Le	ishure			
<u>a</u>	S S S		19a. Informant's Name/Relationship (Ty	pe. Print)		19b. Mailii	ng Address	(Street a	nd Numbe	er or Rura	l Route Numb	er, City or Town,	State, Zij	p Code)
a)	ss t and 2 of Health item 27 i		Dominic Faloni 20a. Method of Disposition	Father	20h Pla	2224	Nort	hfie	1d_Co	ourt,	Finks	burg, M	D 21	L048
٥	of to		1 ☐ Burlal 2 ☐ Cremation 3 ☐ F	lemoval from State	cer	netery, crei	matory or o	ther place	9) ;					
Baltimore,			4 □ Donation 5 □ Other (Specify)  21. Signature of Funcial Service Ligens	ee , ,	Ca:		Crem. 2. Name an			1/9		Hampst Reister		
g	permit. Departr Imports any Inji		79111	1/1/11	1111		line					erstown		
	w.		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of	ications that caused	the death.								, 12	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SE.	EDD	DRE	MAH	V D	+ 4	9 17	ules			Onset and Death
	/Medical		resulting in death)	Due to (or as	a conseque	nce of):		MICH	13	-	,,,,,		-	[MINU.CS
г	Examiner		Sequentially list conditions.	),										
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, [Disease or injury	Due to (or as	a conseque	nce of):								
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):		_					-+	
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89	The law requires that the death certificate the has been signed by the attending phys age 2 should be detached for use as the	edic												
Box	h cert ending	M/u	IF FEMALE: 23b. Was decedent pregnant	3c. if yes, outcome			∃Ectopic pr	agnanov				23d. Da	ite of deliv	ery
	deat e atte	sicia	in the past 12 months?  1 Yes 2 No	4□Pregnant a			Other (sp				VA	Mo	onth /	Day Year
P.0	w requires that the de been signed by the should be detached	Physician/Medi	3 LICIKIOWII			See See Alexander					00- 011			
Ś	res the	by	Part II. Other significant conditions co	ntributing to death b	ut not result	ing in the u	naeriying c	ause give	n in Part I.		23e. Did t	2/		the cause of death? bably 4 □Unknown
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ě	has has by	)du					-				24a. Was	psy		opsy findings available ompletion of cause of
Vital Records,			25. Was case referred to medical							4 =	1□ Yes	2DNo	1 ☐ Yes	2 <b>⅓</b> No
	rsicia s certi lirecto	o Be	examiner?	lospital:	ent 2∐El	R/Outpatier	nt 3□ DO	Othe	r.		(Check only o	one) dence 6 □Oth	· · · · · · · · · · · · · · · · · · ·	(5.1)
Division or	g Phy er this eral c	<u>ان</u> کو	27. Manner of Death	28a. Date of inju	ıry 2	8b. Time o		8c. Injury Work				how injury occur		iy)
Ö	ath. ath. or: Aff	atio	1	(MOINII, Da	A	Injury	FT-M	1 🗆 Y	es 2 🔀	No		NA		
<u>S</u>	r Atto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inj building, et	ury - At hom c. (Specify)	e, farm, str	eet, factory	, office		2	8f. Location (a	Street and Numb wn, Stat <b>e</b> )	er or Run	al Route Number,
	oital ours af					, L	14	-1.46 - 12				NA		
	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	ner: On the basis of and manner st	of examination	eage, aeat on and/or in	vestigation	at the tim , in my op	e, date an pinion, dea	id place, a ith occurre	and due to the ed at the time,	date and place,	anner as s and due t	stated. to the cause(s)
	To the vithin To the Somple	Me	29b. Signature and title of certifier				290	. License	number			29d. Date signe	d (Month,	Day, Year)
)	->-0		>X/ notrace	do.				PI	881	ĺ		DILC	17/	> 007
,			30. Name and address of person who co	ompleted cause of c	leath (Item 2	3a) (Type,	Print)	* !	1	1		-, 10		
			NEELIMA	KATIAGA			Sin	ai H	ospit	tal_				
3 3	Sta		31. Date filed (Month, Day, Year)	- Charles - Char	ar's Signatu		/	<b>6</b>						
DH	Registr MH 17 Rev 1/2		JAN 2 2 20	07	40 A	1	BAR.	•						
חחים	mi i/ nev i/2	JU 1	we will be to the	A.C.		•	GINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:00 a M Dobbl rmac /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lochearn Future Care Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 6, 1944 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F 62 Yrs Phillipines 562-86-2053 Usual Residence of Decedent **Director** with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or Items 23a or 28a-f shov idical Examiner must be notified at Yes 2□No Maryland N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2006 Eagle St. 21223 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No 1967 − If Yes, Give Year or Dates: 1991 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Filipino þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ulth and Mental Hygiene. 27 is marked other than " r traumatic event, the Mex Elementary/Secondary (0-12) College (1-4or 5+) Janitorial U.S.P.S. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Domingo Firmacion Patricia Mariano ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. Angela Sanders, daughter 702 Shipley Ct. Linthicum, MD. 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MD Veterans Cemetery XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-24-07 Crownsville, MD of Crownsville 21. Sign ture of Funer Service L Ambrose Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. 21227 Approxima e Interval Between Onset and Death Arbutus, MD. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a Id be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si should b 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 1 ☐ Yes 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending investigation 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division or Vital Records. Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the

X

State Registrar

and manner stated

3100 Saint Paul St.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Dav. Year)

30. Name and address of person vio completed cause of death (Item 23a) (Type, Print)

ESTRICK 31. Date filed (Month,, Day, Year)

29b. Signature and title of certifie

JAN 2 5 **ORIGINAL** 

DHMH 17 Rev 1/2001

	_		1- State of Maryland		artment of Health and I rtificate of Death		iene 007	01873
	Physic		Decedent's Name (First, Middle, Last)     RICHARD EMMETT FORD			2. Date of Dear Month	Day Year	3. Time of Death 0708 M
	/Medi Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Deal	4
	Funeral		ST. AGNES HOSPITAL  5. Social Security Number  6. Sex  7. Age (In yrs. Ia.	st birthday)	BALTIMORE  If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	N/A 9. Bird	hplace (State or Foreign
	Director		577-38-5921 1\(\begin{array}{cccccccccccccccccccccccccccccccccccc	3 Yrs.	Months Days Hours Min.	SEPT 21		NSYLVANIA
	Aarylan show	ō		Town or Lo	cation			10d. Inside City Limits
	or 28e-	Director	MARYLAND BALTIMORE  10e. Street and Number	CAT	ONSVILLE 10f. Zip Code	1	0g. Citizen of What Co	1 ☐ Yes 2/OXNo untry?
	eath w	Funeral [	921 SOUTHRIDGE RD  11. Marital Status  12. Was Decedent Ever in U.S.	12.1	21228		U.S.A.	
036	d within 72 hours after death with the Maryland ilene. r than "natural", or Ilems 23a or 28e-f show Tre Medical Exercitive must be notified at	by	1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  2. Was deceding to 1.5. Armed Forces?  1 Mayes 2 No If Yes, Give Year or Dates: 42/45	, in	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	ncan Indian, a, etc. BLACK
21215-0036	G 1 3	eleted	(Specify only nignest grade completed)	(Give	lent's Usual Occupation kind of work done during most of work	ring	16b. Kind of Business/	Industry
d 212	Hyg Hyg ent,	e Completed	Elementary/Secondary (0·12) College (1-4or 5+)  12th grade  17. Father's Name (First, Middle, Last)		CHIATRIC AIDE  18. Mother's Nam		IIH/VETERAN	IS ADMIN
Maryland	d ala	To B	RICHARD FORD			e ( <i>fiisi, middie, n</i> IE THURST	•	
Mar	s 1 and 2 should f Health and Men item 27 Is marke other treumatic		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) Shirley Ford/Wife		g Address (Street and Number or Run			
Baltimore,	m O		20a. Method of Disposition  1XXeurial 2 Cremation 3 Removal from State	e of Dispos netery, crem	natory or other place)	Date 2	Oc. Location - City or	Town, State
Baltin	permit. Page Department Importent: If any injury or once.		'4 □ Donation 5 □ Other (Specify) GAR  21. Signature of Exercise Tax Say, a Light to	WI	Name and Address of Facility LLIAM C BROWN COM	MUNITY F	WINGS MILL UNERAL HOM	
			23a. Part Librier we disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	12	06 W NORTH AVENUE			Approximate
2	Pnysician /Medical				ic corenary			Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, faculing to immediate cause. Enter Underlying	= r o t.	ic covenary	arter	- direcere	20 year
	axecuted and al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequent)					
68760,	ficate be executed physician and sthe burial-transit	edicai E	d					
.O. Box (	The law requires that the death certificate has been signed by the attending yage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 🗆	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
<u>ഗ്</u> വ്	res that igned by be deta	by	Part II. Other significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions contributing to death but not resulting to the significant conditions condition			23e. Did toba	cco use contribute to	he cause of death?
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		e Completed	25. Was case referred to medical		00 80 4 9	24a. Was an autopsy performe	ed?   death?	opsy findings available impletion of cause of
Division of V	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director;	ation: To B	07.14	/Outpatient b. Time of Injury			ce 6 Other (Special injury occurred	(y)
DIVIS	ital or Atters and a street or	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	et, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	Il Route Number,
	n 24 hou n 24 hou ne Fune pletely fil	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowled to make the best of my knowled the best of my knowled to make the best of my knowled the best of my	dge, death of and/or inve	occurred at the time, date and place, a stigation, in my opinion, death occurre	and due to the cau	se(s) and manner as s and place, and due to	tated. the cause(s)
	To ff To ff	2	29b. Signature and title of certifier		29c. License number	290	. Date signed (Month,	Day, Year)
	5+1		30. Name and address of person who completed cause of death (Item 23)	a) (Type, Pi	D00525	40 50	envary 17	2007
100	<i>y</i>		30. Name and address of person who completed cause of death (Item 23)  Thomas J. Enelow M.D St. 1  31. Date filed (Month, Day, Year)  33. Date filed (Month, Day, Year)  34. Date filed (Month, Day, Year)	Janes	Hospital -900	Caton F	luenue-Bal	timore M.D.
	Stat Registra	e ar	JAN 2 5 2007	· Con	affe d			,

Albert Faces, Jr.  Albert Faces,				1 - For State Registrer	State of Marylan	•	artment of F rtificate of			Rag. No.	7 01874
Albert Fares, July (Control of Desired Control On Control		Physici	an	Decedent's Name (First, Middle, Last							3. Time of Death
Durisdon   Durisdon		/Medic	al				4h City Town o	or Location of Dea			-
Security   Security		Examin	er						uu i		
Physician   Directors   Dire		Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs		rth 9.	Birthplace (State or Foreign
Usual Realization of Diseaseman   1000 City, Town or Location   1001 Inside City Limits   1001 Inside City Limits   1002 State   1005 City, Town or Location   1004 Inside City Limits   1005 State   1005 City Report   100				236-66-9808	]M 2□F 64	Yrs.	Months Days	Hours Min			
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Physicial (likedical Examinor)  Requiring in death)  Sequentially ist conditions, and the sequence of the sequ				23a. Part1. Enter the disease, or comp	lications that caused the seat	h. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory a	arrest,	Approximate
Securing in death   Due to (or as a consequence of):	c	hysician	- 0	Immediate Cause (Final	ne cause on each line.	10	Α.				
Sequentially list conditions, if any leading to immediate cause. Enter Underlying cause. Enter Underlying that inflated events in the past 12 months?    Part   Par		/Medical			a. Due to (or as a conseq	uence of):	cerm	como	er_		Smonths
Due to (or as a consequence of):    Comparison of the property	E	Examiner		Sequentially list conditions	b						
FEMALE:   23d. Date of delivery	1 7	g .#	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
FEMALE:   23d. Date of delivery		and I-trans	хаш	that initiated events	c	uence of):					
FFEMALE:   23b. Was decedent pregnant   1		be ey									
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Securacelan MP DA5530 01-24-07  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  2 SICASA ICAM, 9118, Philade phias road, Suite 208, MD-21237	5	s ueen s	eted						-		
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Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vaar **Physician** Willie Gandy 01:10 A M 24 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9: Birthplace (State or Foreign VA Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 251-26-7682 Usual Residence of Decedent 926 South Carolina 10XM 2□ F Director with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 1400 ( 11. Marital Status Son 212 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Mudical Ferr 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: Š 3 ☐ Widowed 4 ☐ Divorced DIAC Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be treddie 0 Ganai 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5029 We 20b. Place of Disposition (Name of ones 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory 22. Name and Address He fillipy Joseph L. North Ave. Balto. Md. 21. Signature of Funeral Servic Licenses 1). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non-Small Cell Carcinoma of the Lungs Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached 9☐ Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Peripheral Vascular Disease 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy 2 D No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending P within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/24/2007 Adam B. Edwa P21186 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St. Baltimore, MD 21201 Adam B. Edwards 31. Date filed (Month, Day, Year) State JAN 2 5 2007 Registrar

DHMH 17 Rev 1/2001

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	Funeral		Social Security Number 6. 5		e (In yrs. last birthday	Months Da			Birth (Day Year)	9. Birthplace (State	or Foreign
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	pu ,		Usual Residence of Decedent		10c. City, Town or L	ti				10d. Inside	City Limite
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	tams	nue	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent If Yes, specify (	of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or I rto Rican, etc.)	No- 14. Rad Blad	ce - American Indian, ck, White, etc.	
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121	filed within 72 hours after Hygiene. ther than "natural", or Ita int, it a Medical Extraire	ပိ	17. Father's Name (First, Middle, Last	, yr	1,410	1111-21			lle, Maiden Surfan	ne)	
ano	ntal h	Be	T		•		Roxiv	$\alpha$	Nosl.	211	
Maryland	ges 1 and 2 should be filed within 72 h nt of Health and Mental Hygiene. If item 27 Is marked other than "natu or other traumatic event, Its Medical	T0	19a, Informant's Name/Relationship	Greer	-	ing Address (Str	reet and Number or F	Pura I Poula Nua	ther City or Town	State Zin Code)	
Z Z	12 st h and 7 Is r traur		19a. Informant's Name/Relationship	7 1.1.1	\ QI	August (51)	A - Lall - (	7~ \\ \_L	.202/) N	11.1 /c Al	D Z/115
	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tr. ence.	7	20a. Method of Disposition	n (Wite	20b. Place of Disp	osition (Name &	IS HIGHES.	Date Date	/UW	ngs M. 173, M.	V 21111
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Bal	permit. Pa Departmer Importent any injury once.		21. Signature of Funeral Service Vice	See U	2	Ware and A	dress of Cacility	Feene 1	uneral	15ervice	3
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			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lir	I the death. Do not en ne.	ter the mode of	dying, such as cardia	c or respiratory	arrest,	Approxim Interval B	Between
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Ć.	be executed ician and burial-transit	Еха	resulting in death) Last	Due to (or as	a consequence of):						
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	res that the de igned by the a be detached f	P	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause	given in Part I.	23e. Die	d tobacco use con	tribute to the cause o	f death?
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Division of Vital Records,	Attending Physician: The la ir death. ector: After this certificate ha: by the funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			Othor	eath (Check onl			
of.	shys this al dir	T <sub>0</sub>	1 ☐ Yes 2 No	1 Minpatie		III JU DOA	4 U Nuising		sidence 6 Oth		
- L	Jing F	on:	27. Manger of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time (		Injury at Work?	28d. Describ	e how injury occur	red	
Sio	eath. or: A	cati	2 Accident investigated				1 Yes 2 No				
ï≥	or Att	Certification;	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Injusting, et	u <b>ry - At home, farm, s</b> c. <i>(Specify)</i>	reet, factory, off	lice	28f. Location City or 7	(Street and Numb Town, State)	per or Rural Route Nu	ımber,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral										
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier 1 ★ Certifying P (Check only 2 ★ Medical Exa	hysician: To the best miner: On the basis of	of my knowledge, dea f examination and/or i	th occurred at the	ne time, date and place my opinion, death occ	e, and due to the time	ne cause(s) and ma e. date and place.	anner as stated.  and due to the cause	∍(s)
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	7		30. Name and address of person who		leath (Item 23a) (Type						
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	Sta	ate .	31. Date filed (Month, Day, Year)	32. Registr	leath (Item 23a) (Type evic 5+ ar's Signature	neath)					
	Regist	rar	JAN 2 5	2007	S. 10. 19	1000					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 22, 2007 1:30 P Gino Gentile, Jr. James /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore 8 Glade Avenue Nottingham Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day Y July 12, 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F Maryland 59 1947 213-52-3415 Director Usual Residence of Decedent Pages 1 and 2 should be fited within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Be Completed by Funeral Director Nottingham Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? u.s.A. 8 Glade Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specity: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Dealership Auto Technician or other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gino Gentile, Sr. Anna Louise Pezziza James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 Glade Avenue, Nottingham, MD f Heelth i 21236 Geraldine A. Gentile (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 ☐ Øremation 3 ☐ Removal from State Department of Important: If eny Injury or pace. Gardens of Faith Cem. 1/26/2007 Baltimore, Maryland 4 Donation 5 Other (Specify) 21 Signature of Furieral Service License 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final month **Physician** ancicato resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending nours efter death.

neral Director: Ai 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours e To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ()NEOLOU-1ST 29d. Date signed (Month, Dey, Year) 29b. Signature a nd title of c 0056919 eted cause of death (Item 23a) (Type, Print) Charles St Baltomor Registrar's Signature 31. Date filed (Month, Day, Year) State 2 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 2007 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 98 DUI If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Age (ir) yrs. last birthday) 1 ☐ M 2 🔭 212-22-1049 Director 91 NOV 05 1915 SOUTH CAROLINA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo MARYLAND ANNE ARUNDEL CO GLEN BURNIE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 298D MOUNTAIN RIDGE CT. 21061 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3XXWidowed 4 ☐ Divorced Specify: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4th grade SEAMSTRESS ILGWU 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES CHEEKS IDA POWERS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 is any injury or other trau Katrina P. Pilgrim/Daughter 298D Mountain Ridge Ct., Glen Burnie, Md., 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 01-26-07 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Darbara C Bron 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causes a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Due to (or as a one quence of) /Medical **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (of as a consequence of). the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 TYes 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DCA 5 Residence 6 □Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Tes 2 🗌 No 2 ☐ Accident To the Funeral Director; 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at Certifiler (Check only one)

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Certifil 29a. Certifier 29b. Signature and title of certifier D005964

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Completed cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year 943 AM **Physician** Gilliam narles 20 200 lan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ba etimore Maryland Medical University of enter If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 1⊠M 2□ F Director MARYLAND 20 1949 213-52-5846 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Item 27 is marked other than "natural", or iteme 23e or 28a-f show other treumatic event. Its Mudical Examinar must be notified at 1XX es 2 □ No Directo BALTIMORE MARYLAND N/A 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 U.S.A. FEDERAL STREET 1805 E. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 KXes 2 □ No If Yes, Give Year or Dates: 79/80 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: BLACK 3 ☐ Widowed 4XX Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry d 2 should be filed within : h and Mental Hygiene. 7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION LABORER 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANNIE M. HANSON JOHN HENRY GILLIAM ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 1805 E. Federal St., Baltimore, Maryland 21213 George Gilliam/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 Burial 2 Cremation 3 Removal from State ō Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 01-29-07 GARRISON FOREST OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Darbara slow 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician AIDS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? į 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 sl autopsy 2D No Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1X Inpatient 10 1 🗌 Yes 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 Mo death. Director: 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à determined 4 \ Homicide filled in 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) To the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Joanna

31. Date filed (Month, Day, Year)

JAN 2

5

32. Registrar's Signature

Baltimore

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 2Tay 200<del>7</del>ar 4:15 John Hayden PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 15805 Wayne Avenue Prince Georges Laurel If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year Dec. 3, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 M 2 □ F New Jersey 78 Director 131-22-9195 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notifled at Director Maryland Prince Georges Laurel 1 K Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15805 Wayne Avenue 20707 United States America Funeral 14. Race - American Indian "natural", or items dical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White þ Specify. 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) US Government Government Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic even ၉ William Daniel Hayden Mildred Tietjen Health and Ntem 27 is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 70 Sylvan Street Melrose, MA 02176 Deborah Cronin-Waelde/Cousin other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation √5 ☐ Other (Specify) Metro Crematory 01/24/2007 Catonsville, MD permit. 21. Signature of Fu neral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Rd Laurel, MD 20707 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence, 6): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or la a consequence of) The law requires that the death certificate be executed Exami Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown been signed the should be det ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 3 Probably 4 Unknown 2□ No Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 20110 Hospital: Certification: To 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Injury 1 Tes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760,

Division or Vital Records, To the Hospital or Attending Physician:

g

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 25 2007

29b. Signature and title of certifier

30. Name and address of person who con

4 ☐ Homicide

29a. Certifier

impleted cause of death (Item 23a) (Type

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 35 MARY HOXTER 0 2C2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMOR ( If Under 1 Year | If Under 24 Hrs. ) JOHNS HOPKINS BANDEWHEDICAL CENTER 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number Date of Birth (Month, Day, **Funeral** Days Hours <sup>Year)</sup> 1962 1 □ M 2 🗙 F 216-72-7323 June 6, 44 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside Cify Limits 10b. County 1 ☐ Yes 2 XNo Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is an Injury or other traumatic event, the Medical Examiner must be Is an Injury or other traumatic event, the Medical Examiner must be Is an Injury or other traumatic event, the Medical Examiner must be Is an Injury or other traumatic event, the Medical Examiner must be Is an Injury or other traumatic event which is a second event with the Injury of the 1949 Dineen Drive 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛛 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 11 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Agnes Benick Joseph Lutinsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2400 Cabernet Court, Fallston, MD. 21047 Sister Daphne Rodgers 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Januarv 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State Sacred Heart of Jesus Cem. 27, 2007 Dundalk, MD. signature of Funeral Service License connelly Funeral Home of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SE PSIS UNKNOWN /Medical Due to (or as a consequence of) Examiner PIDEDHOW +1 WEEKS Sequentially list conditions, if any, leading to immediate cause. End underly grade Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ hknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Pes 2 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( (Specify) \) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

The law requires that the death certificate be executed burial-transit and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria the Hospital or Attending Physician: this To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the

Maryland 21215-0036

Baltimore,

State Registrar

29c. License number

29b. Signature and title of certifier \_ HBBS, OPhil

RES-000

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE MD, 2122 ALISHA WADE

31. Date filed (Month, Day, Year) JAN 25 2007



DHMH 17 Rev 1/2001

		1	For State Registrar	State of Maryland /	Department of I			ene g. No. 007	01882
			1. Decedent's Name (First, Middle, Last,				Date of Death     Month	Day Year	3. Time of Death
	Physicia /Medic		HE	ARNESGREE			01 0		2210 M
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town,	or Location of Death		4c. County of Death	
			HOLY CROSS		SILVE		N G	MONTGO	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last b	irthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,		place (State or Foreign intry)
	Director	-	NONE Usual Residence of Decedent		113.	7 2	01053	001 11;	7
	and **		10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	Aaryl f sho	5	TC	2 AIN	HINGTO	111			1 XYes 2 □ No
	the t	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	untry?
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	leath ms 23	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer Black, White	
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	nit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan ariment of Heatth and Mental Hygiene. ortant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examinat must be notified at injury or other traumatic event, the Medical Examinat must be notified at 89.	1	20a. Method of Disposition	20b. Place	of Disposition (Name of			Oc. Location - City or	
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altimore,	permit. Pages Department of Important: If i any injury or ance.		* 4 ☐ Donation 5 ☒ Other (Specify	in state	22. Name and Addi	ress of Facility	. (55 11	D 1.1	G
Ba	permi Depa Impo any i		21. Sign thus of Funeral Service Licens	Wade Director	Baltimore			Baltimore	Street
			23a. Part. Enter the disease, or comp	lications that caused the death. D		<u> </u>		est,	Approximate Interval Between
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9	lificate g phys as the	edi							
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	deat	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 9☐Unknown				World	ou, ou
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f V	nysic nis ce direc	To	1 ☐ Yes 2 No		Outpatient 3 DOA			ance 6 Other (Spec	cify)
0	Attending Physician: r death. ector: After this certifics by the funeral director. I	Ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	o. Time of 28c. Inj Injury W		28d. Describe ho	w injury occurred	
Ö	ttendir death. ctor: Af y the fu	atic	2 ☐ Accident investigation			☐ Yes 2 ☐ No	201 (2)		and Courte Missister
Division of Vital Records,	or Atternation of Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, offic	:0	City or Town	reet and Number or Ru n, State)	irai Houte Number,
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	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	ledical	(Check only 2 Medical Exert	sician: To the best of my knowled inner: On the basis of examination	dge, death occurred at the and/or investigation, in my	time, date and place y opinion, death occu	rred at the time, d	ate and place, and due	to the cause(s)
	the I	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. Lice	nse number	2	9d. Date signed (Mont.	h, Day, Year)
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			30. Name and address of person who	completed cause of death (Item 23	a) (Type, Print) ol3 GRORGI	IA AUR	CILVED	SPRIATE !	CUBUC UM
			DARRYN BY  31. Date filed (Month), (Year)	2007 32. Registrar's Signatur	A ALCONO	JALLI KILL	DIM KR	3110100	in a rea
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DHMH 17 Rev 1/2001

Registrar

2007

			For State Registrar	State of Marylan		artment of H rtificate of I			ienė 0 7	01884	
	Physici		1. Decedent's Name (First, Middle, Las. John Edward Hart					2. Date of Deat Month	2 Pay 200	3. Time of Death 8:50 A M	
	/Medic Examin		4a. Facility Name (If not institution, give 100 Kent Point Ro			4b. City, Town, or Steven	Location of Deat	h	4c. County of D		
	Funeral Director		5. Social Security Number 6. Se 212-40-4975	7. Age (In yrs. 63	last birthday) Yrs.	ff Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	9.1 9.1 9.1	Birthplece (State or Foreign Country) MD	
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	h with the 23e or 28 at be not	Funeral Director	10e. Street and Number 100 Kent Point Ro	oad		10f. Zip Code 21666	6	1	0g. Citizen of What USA	Country?	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23s or 28s-1 show other traumatic avant, the Madical Examinar must be notified at	É	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (S in, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		merican fndian, /hite, etc. white	
Maryland 21215-0036	s within 72 ho jene. r than "natur the Madical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) Coffege (1-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired .f-employe	during most of wo f)	rking	16b. Kind of Busine Automot	motive	
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Mary	nd 2 should lith and Men 27 is marke r treumatic		19a. Informant's Name/Relationship (7 Mr. John E. Hartle	• • • • • • • • • • • • • • • • • • • •		ng Address (Street A			City or Town, State	e, Zip Code)	
Baltimore,	permit. Peges 1 and 2 Depertment of Health a Important: if Item 27 is any injury or other tree		20a. Method of Disposition  1 Reurial 2 Cremation 3 4 Dogation 5 Other (Specify	Removal from State	emetery, crer	sition (Name of matory or other place n Cemeter	e) 1/2		20c. Location - City Glen Bui		
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	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resufting in death)	a. Non Small	1 cel	er the mode of dyin	g, such as cardia		est,	Approximate Interval Between Onset and Death 2 Years	
	Examiner	-	Sequentially fist conditions,	b. Due to (or as a conseq		J					
8760,	The law requires thet the death certificate be executed the best been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):						
9	entificate ling phys e as the	Medical	IF FEMALE:	d							
P.O. Box	thet the death certific ed by the ettending p detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year	
	w requires thet been signed b should be deta		Part fl. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tol		e to the cause of death? Probably 4 □Unknown	
Division of Vital Records,		Completed						24a. Was a autops perform	n 24b. Were prior death	autopsy findings available to completion of cause of 1? (es 20 No	
Z Ziti	Physician: The this certificate al director, pag	To Be	25. Was case referred to medical examiner?  1 Yes No	Hospital: 1 ☐ fnpatient 2 ☐	ER/Outpatier	at 3 DOA Oth	or:	ath (Check only on	ence 6 ⊡Other (S	Specify)	
sion o	B 9 9	Certification;	27. Manner of Feath  1 Natural 5 Pending investigation		28b. Time of Injury	Worl	yat k? Yes 2 ∐No	28d. Describe ho	ow injury occurred		
Σ Ω	To the Hospitel or Attandin within 24 hours after death.  To the Funeral Director: At completely filled in by the fur	Certific	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Specify	(y) 			City or Town	n, State)	Rural Route Number,	
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in by	Medicai	29a. Certifier (Check only one)	ysitian: To the best of my kno iner: On the basis of examina and manner stated.	wiadge, daatt	vestigation, in my o	ne, data and place pinion, death occi	and due to the ex urred at the time, d	ate and place, and o	due to the cause(s)	
	To Toon	2	29b. Signature and title of certifier	weins, n	10	DS 29c. Licenso	2830	2	9d. Date signed (M Janvary	22, 2007	
	15		30. Name and address of person who of Jeanine Wern	completed cause of death (Item	п 23a) (Туре, ЭВСSН	Print) Cate Loc	d #3	20, Anna	epolis, M	10 2140/	
spirit,	Sta Registi		29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who of Jeanine Welvin  31. Date filed (Month, Dey, Year)  JAN 2 5 200	32. Registrar's Signa	ature	lis					

villiam Edward		1- For State Certificate of Deal Registrar	th	2007 0188
Physic Medical Exam		Decedent's Name (First, Middle,Last)  William E. James	2. Date of Dea Month <b>January</b> 2	Day Year
and the same of th		4a. Facility Name (if not institution, give street and number)  4b. City,	Town, or Location of Death y Hall	4c. County of Death  Baltimore County
Funeral Director		220-66-1021 1XM 2 F 40 Yrs. Mont	hs Days Hours Min	irth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
ith the Maryland 23a or 28a-f show any notified at once.	or	Usual Residence of Decedent  10a. State		10d. Inside City Limits 1 Yes 2 X No
	Director	10e. Street and Number 10f. Zij	p Code 21128	10g. Citizen of What Country?  USA
r death w	Funer	yvidowed 4 Divorced in res, Give real 1 Yes 2	lent of Hispanic Origin? (Specify Yes or No ify Cuban, Mexican, Puerto Rican, etc.)  No specify:	White, etc.  Specify: White
11215-0036 Id be filed within 72 hours after fental Hygene ranked other than "natural", event, the Medical Examiner.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  2yrs  16a. Decedent's Usual during most of wo Manager	I Occupation (Give kind of work done orking life. DO NOT use retired)	Brand Services Inc
21215-0036 uld be filed within 7 Mental Hygiene marked other than	o Be Co	Frank James 111	18.Mother's Name (First, Middle,  Linda Lauk s (Street and Number or Rural Route Nu	teman
MD nd 2 shot alth and m 27 is		Kimberly James /wife 5118 C	rest HAven Way P	Perry Hall MD 21128
Baltimore, MD 21218 permit Pages I and 2 should be fil. Department of Health and Mental H Important: If iten 27 is marked injury or other traumatic event u.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Na crematory or other place Bayview Cre	matory 1/24/07	20c. Location - City or Town, State  Baltimore MD
Balti permit Departm Imports	7	Conn	elly Funeral Hom	e Avenue Balto MD ne of Essex 21221
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that cauded the death. Do not enter the mode failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CDntact Gunshpt Wpund pf Head  Due to (or as a consequence of):	of dying, such as cardiac or respiratory and	rest, shock, or heart Approximate Interval Between Onset and Death
	iner	Sequentially list conditions, b		
uted od ansit	Examiner	0		
60, atte be executed thysician and be burial - transi	Medical	UNPENDED AMENDED		
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the fineral director, page 2 should be detached for use as the burial - transi	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 5 Other (Special Representation of Special R		23d Date of delivery  Month Day Year
P.O. rres that the signed by leed etache	þ	,	g cause given in Part I. 23e. Did t	obacco use contribute to the cause of death?  s 2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, F and or Attending Physician: The law requires as after death.  The Director: After this certificate has been signed in Joyen founted death.	Completed		24a. Was autoj perfc 1 <b>v</b> Yes	psy prior to completion of cause of death?
Vital Rec ysician: The list certificate linector, page	a	25. Was case referred to medical examiner? Hospital: 4 Inpution: 2 FP/Outpution: 3 In	26.Place of Death (Check only one)  DOA Other Nursing Home 5	Residence 6 🗸 Other; Scene
ion of Vit ttending Physic teath. tor: After this of the funeral dire	ation: To	27 Manner of Death 28a Date of Injury 28h Time of Injury		how injury occurred
Division of Nother Hospital or Attending Physicial or Attending Physicials as April 170 the Fumeral Director: After I completely filled in by the funeral	Certification:		or Town, S 5118 Crest H	laven Way, Perry Hall, MD
o the H	Medical	Certifying Physician: To the best of my knowledge, death occurred at the one)   Certifying Physician: To the best of my knowledge, death occurred at the one)   Medical Examiner: On the basis of examination and/or investigation, in mand manner stated.		
	Me	29b. Signature and title of certifier  Pollok so	O.C.M.E.	29d Date signed (Month, Day, Year)  January 23, 2007
			Penn Street, Baltimpre, MD 2120	11
Regis	tate strar	10110 - 0007 %		
Drivin T/ Rev I/	200 T	ORIGINAL		

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			For State Registrar	State of Marylan		artment of H rtificate of I			iene U U / ng. No.	01000					
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month		3. Time of Death					
	Physici		Charles Henry Kam	nhaus				January	15, 2007 ear	9:00 AM M					
ja.	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	1	4c. County of Death									
		Ŭ.	1909 Cypress Driv	re		Be1			Harfo	ord					
	Funeral Director		5. Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 3,	9. Bir 1920 Mary	thplace (State or Foreign punity) 7 Land					
	Maryland a-f ehow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits					
		ż	MD Harford		Be1	Air									
	h the	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Country?						
	h wit		1909 Cypress Dri	ve			21015		USA						
d 21215-0036 Illed within 72 hours after death with the Maryland Hygiene therithen "natural", or Items 23a or 28a-1 show ent, the Mexical Examinant must be incutified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married  1 ☑ Yes 2 □ No  1 ☑ Yes 2 ☑ No  1 ☑ Yes 2 ☑ No  1 ☑ Yes 2 ☑ No  1 ☑ Yes 2 ☑ No  1 ☑ Yes 2 ☑ No Specify:						14. Race - Ame Black, Whit Specify: W	le, etc.						
	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	king	16b. Kind of Business	of Business/Industry unk									
7	within then the Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired Lneer	1)								
Ö	t Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	Maiden Sumame)	unk					
a	lenta be riked riked	To B	Charles Neimut	h Kamphaus											
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 ehow any Injury or other traumatic event, the Medical Examinar must be multipled at once.		19a. Informant's Name/Relationship (7 Lillian A. Kamph			ng Address (Street Cypress			City or Town, State, 21015	Zip Code)						
	Peges 1 ar nent of Hea int: If Item iry or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specify	20c. Location - City or	ty or Town, State										
Balti	permit. Departn Imports any Inju		21. Signature of Europa Strong Strong Strong Strange and Address of Factor Baltimore, MD 21201												
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	Offications that caused the deat one cause on each line.	h. Do not ent		est,	Approximate Interval Between Onset and Death							
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	,	,									
	عبد	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	иенсе ођ.										
	ecuted and -transi		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
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P.O. Box	To the Hospitel or Attending Physician: The law requires thet the death certif within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of degree Unknown		23d. Date of de Month	delivery Day Year								
ds, P.	uires thet t signed by td be deta	۵	۵	ρ	ρ	ρ	٥	Part II. Other significant conditions of Demention	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		pacco use contribute to	o the cause of death?
Division of Vital Records,	The law require te has been si age 2 should t	Completed			-			24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of					
ta	tifice tor, p	0	25. Was case referred to medical				26. Place of Dea	ath (Check only on							
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o uc	ling Ph		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	yat k? Yes 2 □No	28d. Describe how injury occurred									
Division	l or Attence after death Director: I in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			28f. Location (Street and Number or Rural Route Number, City or Town, State)									
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)	To th withir To th comp	Me	29b. Signature and title of certifier	ND		29c. Licens	5 0/2		9d. Date signed (Mon	th, Day, Year) 19, 2007					
			30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print) VO -T	Z Av	e. Be	14:01	71.21014					
	Sta Regist		31. Date filed (Month, Day, Year)  JAN 2 5 20	32 Registrar's Signal	ature An	notes									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 23 Day Month **Physician** 2110 PM Ke ZAbeth 2007 01 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospice At THE Willmic 15bur 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ▼ F Months Days Hours 213-34-6968 98 Director 11-20-1908 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at ¥Yes 2 No Director WP BALTIMORE LNDACK 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 10WNSHip ROAD 51333 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" -- " any hijury or other traumatic even." Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose KALKREUT ouise Lul ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) relbyvilla William Kelly DE Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1-25-2007 Bruimore 4 □ Donation 5 □ Other (Specify) MD 21224 2134 21. Signature of Funeral Service Licens 22. Name and Add s of Facility Willow SPRING ASHOW F.H.P.A N 000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ereprovascula disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the attending physician and hed for use as the burial-tran The law requires that the death certificate be execu Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 1 Tes 2 ER/Outpatient 3□ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ロス627 Name and address of person who completed cause of death (Item 23a) (Type, Print) Jours! Coesto 10 BOX 1733 Jevid 22. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of M	larylan		artmer rtificat			and M	_	giene Reg. No. (	200	-7	ΛΙΩ	Ω F	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Pearl Th	owski	-				2. Date of Death Month Day Ye 23, 2007				3. Time of Dea 1:25 F	M			
I	Examin		4a. Facility Name (If not institution, give s Stella Maris				Ti	moni			4c. County of Death Baltimore			Death <b>more</b>	<u>;</u>		
- 9	Funeral Director		213-52-5930	7. A	ge (In yrs. 90	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Aug. 1	7, 19		Birthplac Country Mary	and	reign	
	e Maryland 8a-f show tiffied at	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Md. Baltimore Timonium										I, Inside City Li 1				
	n with the	al Director	10e. Street and Number 2300 Dulaney Va		10f. Zip Code 10g. Citizen o						en of Wha	ut Country USA					
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral		12. Was Deceden Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	? No		Was Dece If Yes, spe 1  Yes		ispanic Ori an, Mexicar Specify:		ecify Yes or No Rican, etc.)		1. Race - Black, 1 Specify:	White, etc			
d 2121 filed within Hygiene. other than " ent, the Me	I within 72 ho jiene. r than "natur the Medical I	Completed	(Specify only highest grade completed) (Give kin life. DO Elementary/Secondary (0-12) College (1-4or 5+)						dent's Usual Occupation kind of work done during most of working DO NOT use retired)  Omemaker					16b. Kind of Business/Industry  Own Home			
	2 should be filed and Mental Hyg Is marked other raumatic event,	To Be C	17. Father's Name (First, Middle, Last) Frank Muller			-				E11a		man					
Mar	and 2 sho lealth and m 27 Is m her traum		19a. Informant's Name/Relationship (Ty Mrs. Joanne C. McC		ıghteı		9				al Route Numb l Air,				code)		
more,	permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once.		20a. Method of Disposition  1 N Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from Stat		Place of Dispo cemetery, cre rdens (	matory or	other plac	Cem.		oate -07		ation - Cit <b>timo</b>	•			
Balti	permit. Departn Importa any Inju		21. Signature of Foneral Service Licensee  22. Name and Address of Facility Ruck Towson Fun 1050 York Rd. T								neral Home, Inc. Towson, Md. 21204						
8760,	Physician (cate be executed by Medical Examiner physician and physician and the phys	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a Due t	s a consecus	quence of):	DISE/	SE									
.O. Box 68	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fet at time of	al death 3[	⊒Ectopic ¡ ⊒ Other <i>(</i> s		/			23	3d. Date o		/ Day Yea	r	
<u>α</u>	uires that the de n signed by the a	by	Part II. Other significant conditions co	ntributing to death	but not re	sulting in the u	ınderlying	cause giv	en in Part	l.			e contribi		cause of deat		
Il Recoi	The law ate has b bage 2 sl	Completed									24a. Was auto perf 1 Yes		dea	ath?	sy findings ava pletion of caus	ilable e of	
Vita	s certificalinector,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ∏ Inpa	tient 2	] ER/Outpatie	nt 3□ D	OA Oth			n <i>(Check only</i> me 5□Res		MOther	(Specify)	HOSPIC	Œ.	
Division or Vital Records,	Division or Vital or Attending Physician: after death. Director: After this certification by the funeral director, in by the funeral director,	Certification: T	27. Manner of Death  1 X Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28c. Injui Woi 1 [] ry, office		]No	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number City or Town, State)										
Ω	Hospital 24 hours a Funeral stely filled	Medical Cer	29a. Certifier 1 Certifying Phy (Check only one)		of examin												
	To the within 2 To the comple	Mec	29b. Signature and title of certifler	-				9c. Licens	se number	25		29d. Date	signed (	Month, D 3/67	ay, Year)		
	5 St	ate	30. Name and address of person who of DR. TARIO MAHMOOD  31. Date filed (Month, Day, Year)	2300 D 32. Regi		Y VALL		), Т	'IMON	IUM,	MD 210	93					

1:25 р.ш.

JANUARY 23, 2007

PEARL KALINOWSKI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** Dorothy Jean Little 2:00 PM anugra 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Citizens HouredeGrace Home 8. Date of Birth (Month, Day, Year)
Itily 10, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 X F 096-16-8108 84 1922 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show other traumatic event, the Medical Exaction part be politised at 1 ☐ Yes 2 No Director Harford Maryland Forest Hill 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1610 D Rebecca Court **USA** 21050 Itema 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ◯ Widowed 4 □ Divorced Specify: White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n Elementary/Secondary (0-12) Coltege (1-4or 5+) Bookkeeper U.S.O. 12 s.1 and 2 should be filed v if Health and Mental Hygie item 27 Is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William C. Andrew Marquerite Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malcolm E. Little, Son 1113 Old Fallston Road Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itee 1 Burial 2 Cremation 3 Removal from State 01/24/07 \* 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Usensee <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Hemorrhae tmmediate Cause (Finat disease or condition resulting in death) ere bral Physician o days /Medical Due to (or as a consequence of): Examiner ı Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) the detached 9 Haknown 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dely dralion 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) P this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 Suicide 28e. Place of tnury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and little of certifier\_ 29c. License number 29d. Date signed (Month, Dav. Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grau MD 21078 Revolution St KAMRUDIN MITHANI MAD aure De 1106

State

Registrar

31. Date filed (Month, Day, Year)

JAN 25

2007

ittle, Doroth

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b.c per fh 863 1-25-07 vt. State of Maryland / Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year RALPH LEE JANUALZY 05:00M 21 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA BALTIMONE CITY

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) JOHNS HOSPITAL HOPKINS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 58 July 18, 1948 Yrs. Director 212-46-1456 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director 1 Ses 2 No Baltimore MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code iteme 23a 21218 USA 1505 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 1 ■ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ō Specify: AFreden Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced America 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) lts more Cox 124 Entinee. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ie marked of Henry Lee Irene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nam Pelationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other of Rosalmo E. Hargrove/sister item 27 i Homestend Street Balthouse MD 21218 other 20a. Method of Disposition Date 20c. Location - City or Town, State Department of himportent: If ite any injury or of once. ry crematory or other pl. Carmel Cen. ₩Burial 2 Cremation 3 Removal from State Baltimore 22. Name and Address of Facility ose Funeral Sewick, P. A.

5126 Belain Road, Bathmore MD ZI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 1 th more MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 3 PAYS /Medical Due to (or as a consequence of) Examiner CIRRHOSIS YEARS Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or ripury that initiated events resulting in death) Last Examiner Directo for as a nonsequence of use as the burial-trensit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, sete hes been signed by the attending physicien page 2 should be detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 ☐Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificete is after deam.
rai Director: After this ce....
in by the funeral director, pa 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending М 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AFSHAR RES-000 JANUARY. , MEDICAL DOCTOR ,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KIA AFSHAR, THE 31. Date filed (Month, Day, Year) JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMOZE, MIRYUND 21287 32 egistrar's Signature State JAN 2 5 2007

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 4:07 PM **Physician** William Morawski, Jr. 20 - 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital cente soultimore Square If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 30, 1931 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F 75 215-28-9226 Yrs Maryland Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1315 Chesaco Avenue, Unit 108 21237 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1. □Yes 2 □ No
If Yes, Give Kohean
Year or Dates: Conflict 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 □ Widowed 4 Divorced "naturai" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Street Sales Sunpapers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be No raws 1/3; Pages 1 and 2 should be nent of Health and Mental William Morawski Genevieve Zielski. ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Morawski, III (son) 9519 Holiday Manor Road, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 1/25/2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** espiratory tailure /Medical Due to (or as a consequence of Examiner Piration Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to for as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit a a consence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide within 24 hours efter de To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier nderson, M.D. D 6006 4217 Mosen 6+1 30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive, Baltimore, MD, 21237 SON 32. Registrar's Signature 31. Date filed (Month, Day, Year) Sport

**ORIGINAL** 

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year ATSY 16:29 PM MOONE 0 2007 /Medical 4a. Facility Name (If not institution, give street and number 4b City Town or Location of Death 4c. County of Death Examiner RALTIMONE
If Under 1 Year If Under 24 Hrs. KERNAN ORTHOPEDEU Hospital BALTIMORE 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3-23-34 Birthplace (State or Foreign Country) **Funeral** 451-56-4032 1□M 2€F Days Hours Min 68 Yrs. Director TEXAS Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits, or 28a-f shoy other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Numb 10g. Citizen of What Country? Items 23a U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ Who If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Marital Status Was Decedent of Hisp If Yes, specify Cuban, Origin? (Specify Yes or No-can, Puerto Rican, etc.) 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ₩idowed 4 Divorced "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ohn Allen Laco 0 DIXIE SUE PORTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any Injury or other tra Daughter 8101 Holly Ro. LMD. 21226 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HANOVER, MD 22. Name and A 2601 Mountain Road Daugherty Family Funeral Home Pasadena, MD 21122 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (er as a conseq /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. ame and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) State JAN 25 Registrar

Marsteller, Schma Baltimore, Maryland 21215-0036

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iner	4a Facility Na	me (If not institution	n, give street and nu	ımber)		4b. C	ity, Town, or	Location of	Death	)		c. County		\
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4	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										Code)			
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within 24 hours atter death. To the Funeral Director: After this certilicate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Phyelcian: The law requires that the death certiticate be executed Division of Vital Records, P.O. Box 68760, <

> 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and Date signed (Month, Day, Year)
> Tanuary 24 2007 29b. Signature and type of certifier average death (Item 23a) (Type, Print) add Survive Mi) 21061

State Registrar

DHMH 17 Rev 1/2001

Medicai

31. Date filed (Month, Day, Year) JAN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23a per doc 863 1-25-07 vt amend item 31 State of Maryland / Department of Health and Mental Hygiene

1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22,12007 **Physician** BEATRICE HOOKER MARTY JANUARY 11:00a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2020 BELFAST ROAD SPARKS BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 1 (Month, Pay) **Funeral**  Birthplace (State or Foreign Country) 214-20-2940 1 M 2 X F 11977771918 88 Yrs. Director MARYLAND Usuet Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at MD BALTIMORE SPARKS Completed by Funeral Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If I tem 27 is marked other than "--- any injury or other traument— and prigory. 2020 BELFAST ROAD 21152 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 11. Maritat Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify Specify: WHITE 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DONALD R. HOOKER EDITH HOUGHTON 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REED HUPPMAN 16120 DARK HOLLOW RD. UPPERCO, MD. 21155 son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State GREEN MOUNT 01/23/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. ONACO 16924 YORK RD. MONKTON, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Aortic Stenosis Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 pronths? 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA al Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funaral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 03 JAN 282 Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year JANUARY 2007 0502 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NO ADITAI IMD N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2₹F Months Days Hours Min. 42 213-78-4894 Director June 19, 1964 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits "natural", or items 23a or 28a-f shordical Examiner must be notified at Director 1 X Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1631 E. Lafayette Ave. Funeral 21213 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No 3 Specify Specify: White 3 ☐ Widowed 4 X Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry oe filed wn. •al Hygiene. •**er than** "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 N/A N/A N/Apermit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other I any injury or other traumatic event, <u>ti</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Melvin Leon McDaniels Florine Lam 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1631 E. Lafayette Ave. Baltimore, MD 21213 Florine McHan/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mays Chapel Church 20a. Method of Disposition Jan. 25. 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 2007 Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Road Timonium, MD 21093 21. Signature of michael J. Flagle complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, of com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician YERWHELMING /Medical Due to (or as a consequence of): Examiner KENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of): Examine DAGULOPATA burial-trar Due to (or as a consequence of): physician Physician/Medical as the l IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 1 25. Was case referred to medical examiner? director Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 1 🔲 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of D th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

requires that the death certificate be executed Records, P.O. Box 68760 or Vital Division

with the Maryland

death

within 72 hours after

Maryland 21215-0036

Baltimore,

attending certificate Hospital or Attending Physician; this After 1 death. the Funeral Director: filled in by after hours npletely 24

Medical ပ

29a. Certifier (Check only one)

29b. Signature and title of certific

30. Name and address

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

erson who completed cause of death (Item 23a) (Type, Print) NORTH WOL

and manner state

\$2. Registrar's Signature

ALTIMORE

31. Date filed (Month, Day, Year) JAN 2 5 2007

HAMID

State of Maryland / Department of Health and Mental Hygiene, 1 - State Amend #19a, perFH, g866,4/3/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MAYERS ELAINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 308/Timore UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 18 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F Days Hours 082-16-1650 Feb 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County Director New York Kings Brooklyn 10e. Street and Number 10f. Zip Code 273 Lincoln Place Apt# 6 11213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify δ If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph ၉ Fareira Martha Painter 19a. Informant's Name/Relationship *(Type. Print)* **Ingrid U.** <del>Ingris</del> Mayers / Da 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1273 Lincoln Pl. #6 Brooklyn, NY. 11213
lace of Disposition (Name of Date 20c. Location - City or Town, State Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rosehill Cem 01-20-07 4 Donation 5 Dother (Specify) Todd W. Drew 1000 Saint Johns Pl. Brooklyn, NY.11213 21. Signature of Euneral Service Licensee 21 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CUREBELLAR HUMORRANGE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed physician and s the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical nding p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 I DIOPATHIC ulmonary FIBROSIS Completed 24a. Was an autopsy performe 2 12 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Mann of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) P18600 MD 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death 2236 M 200 7 4c. County of Death Year) 1930 st. Vincent 10d. Inside City Limits 1 XYes 2 □ No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry / Private Garment Linden, NJ. Approximate Interval Between Onset and Death WEEK 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2007

State Registrar JEFF-REY

31. Date filed (Month, Day, Year)

22 South Greene St.Baltimore, MD. 21201

07-005	60
Evelyn	Norek

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

elyn Norek		State of Maryland / 1-For State Registrar	Certificate		ina ivientai	, 0	200°	7 0189			
Physici edical Exami	an/	1. Decedent's Name (First, Middle, Last)  Evelyn D. Norek				2. Date of Dea Month January 2	ath	3. Time of Death 2010 hrs			
-		4a. Facility Name (if not institution, give street and number)			or Location of D		4c. County of Death				
Funeral		Franklin Square Hospital  5. Social Security Number 6. Sex 7. Agr	e (In yrs last birthday)	Rosedale  If Under 1 Y		4Hrs. 8. Date of Bi	Baltimore Cou				
Director		215-03-3687 1_M 2XF	0.0		ays Hours	Min. 02/21,	/1916 Foreig	n untryMaryland			
v any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits			
Maryland r 28a-f show a	ctor	Maryland Baltimore  10e. Street and Number		Baltimo		· [:	10g. Citizen of What Cour	1 Yes 2 X No			
h the Ma 3a or 28	Director	6600 Ridge Road		21	237		u.s.A.				
death wit or items 2	Funera	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Armed Forces? 1 Yes 2		Was Decedent of I If Yes, specify Cub		(Specify Yes or No uerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,			
urs after tural", o	ρ	3 Widowed 4 Divorced of Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade com	1	Yes 2 X I		d of work done	Specify. W	rite			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)  Sub Sho									
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AD 21 2 should 1 and Me 27 is ma matic ev	7	19a. Informant's Name/Relationship (Type, Print)  Lorraine Fisher (siste					mber, City or Town, State e, MD 21234	, Zip Code)			
ore, Nest and Street Health		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from Sta	20b. Place of Disposer	position (Name of other place)	cemetery,	Date	20c. Location - City or				
ItimC nit Page artment ortant:		4 Donation 5 Other Specify:  1 Su of Figure ervice as e					Baltimore, Funeral Hor	_			
		Varin Olmany.		9705 Bel	air Rd.	, Baltimo	re, MD 2123	5			
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		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.									
	niner	if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated	equence of);								
uted nd ransit	l Examin	events resulting in death) Last Due to (or as a conse	equence of):			<del></del> -					
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cox 68760, eath certificate be executed attending physician and for use as the burial - transit	au	past 12 months?	2		3 Ectopic pr	egnancy	23d Date of delivery  Month E	yay Year			
Box 687 e death certific the attending p	Physici	1 Yes 2 No 9 Unknown 9 Unknown	3 🗆	Other (Specify)							
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Vital hysician this cert	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatie	nt 2 🗸 ER/Outpatio		Other	ursing Home 5	Residence 6 Other				
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Division of Vital Records, P.O. tiral or Attending Physician: The law requires that the rate death rate Director: After this certificate has been signed by lled in by the funeral director, page 2 should be detact	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	jury - At home, farm, s	treet, factory, offic	e building, etc.	28f, Location ( or Town, S	Street and Number or Ru State)	ral Route Number, City			
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans.	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated									
E » E S	Me	29b. Signature and title of certifier		1	ense number	·	29d. Date signed (Mor				
9		30 Name and address of person who completed cause of d	eath (Item 23a)		J.IVI.∟.		January 21, 2007				
4		Carol Allan, MD Assistant Medical Exam	niner 111 Pen	n Street, Balti	more, MD 2	1201					
S Regis	tate	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	20000							

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death OLSON JOHN 23 2007 4c. County of Death 1Anual 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Social Security Number 7. Age (In vrs. last 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Hours 1∭M 2□F Days 216-52-8642 57 Yrs. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 4236 E. Joppa Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Elizabeth Hellwig John Samuel Olson. Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 105 Kenilworth Park Dr., Apt. 1A, Towson, MD21204 Ruth H. Olson (mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 1/27/2007 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MRSA bacteremia months disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause of injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Dav 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 26. Place of Death | Check only one Inpatient 2 TER/Outpatient 3 DOA

Examiner attending physicien and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. this After this funeral of death. Director: / within 24 hours aft To the Funeral Di completely filled in

Examiner Physician/Medical 2 Completed Be 2 Certification: Medicai

**Physician** 

/Medical

Examiner

10a. State

Director

Completed by Funeral

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**Funeral** 

Director

Item 27 is marked other than "natural", or Itema 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If Item 27 is marked other then "natural", or Ite

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Physician

/Medical

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 27. Manner of Death ate of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of sertifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) JAN 2 5 2007

Durana

Christine

2. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.DURAND MD

The Johns Hopkins Hospital 600 North Wolfe St., posts

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JANUARY 23, 2007

			State of Maryland / Department of Health a 1- State Amend #1, perAB, G863, 1/25/07 TT Certificate of Death	and Me		giene Reg. No. 2 () (	37	01899
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				PRIN	6	MONT	60	MERY
	Funeral		5. Social Security Number 6. Sex 12M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Yrs. Months Days Hours	24 Hrs. 8 Min.	Date of Bird (Month, Da	v. Year)	9. Birthpl Coun	ace (State or Foreign try)
н	Director		Usual Residence of Decedent	- (	) & (	3 1937	Le	SA
	yland now at		10a. State 10b. County 10c. City, Town or Location				1	Od. Inside City Limits
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	or 28	Director	10e. Street and Number 10f. Zip Code			10g. Citizen of W	nat Coun	try?
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altimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	Date		200. Location - C	ity or Tov	vn, State
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			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
			KSHAMA GARG MD 1500 FOREST GLEN R	S 05	ILVER	2 SPRIN	GM	D 20910
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			For State Registrar	State of Maryland		rtment of H ificate of L			iene2 () () 7 og. No.	01900	
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28a-f ehow enty figury or other treumatic event, the Madical Examinar must be notified at ORCE.	Completed by	15. Decedent's Education (Specify only highest grade completed)  [Independent of the complete								
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within 24 hours at To the Funeral D

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature

29c. License number

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29d. Date signed (Month, Day, Year)

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9	Page lent o nt: If ry or	ĺ	1 Bunal 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		tery, crematory or other place)	V 1/27/2	DOOR D	cht 100	J
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48	Registra	~	JAN 2 5 2	32 Registrar's Signature	A Comment of the Comm				
DHN	/H 17 Rev 1/20	01		क					

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, hours after death uneral Director:

Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI Eastern blud. 901 32. Registrar's Signature 31. Date filed (Month, Day, DHMH 17 Rev 1/2001 **ORIGINAL** 

Registrar

			1 - For State Registrar	State of M	laryland		artment of rtificate o				giene (	07	01905
	Physici	an	1. Decedent's Name (First, Middle,	Last)		- MIK	CUP			2. Date of Dea		Year_	3. Time of Death
	/Media	cal	I-ERDINAND				,	1 = 1		01	21 2	007	345 AM
1	Examir	ner	4a. Facility Name (If not institution, RAITIMORE REL	ARILITATI	10181	-YTE1	4b. City, Town	APZ	RA/	TIMORE	4c. Coun	ty of Death	
	Funeral				ge (In yrs. Ia	ast birthday)	If Under 1 Ye Months Dar		er 24 Hrs.	8. Date of Birt (Month, Da	h V Yearl	9. Birth	place (State or Foreign
	Director		212-40-0480	1 M 2 □ F	64	Yrs.	WOTHING Da	ys Hours	, will t.	Jan. 20	, 1943	Mari	yland
	land ow	ł	Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation					1.	10d. Inside City Limits
	e-fsh	ctor	Maryland N/A					Balti	more				1 Yes 2 □ No
	or 28	Director	10e. Street and Number		***		10f. Zip Cod		_		10g. Citizen of		ntry?
	99th v	erai	815 N. Luzerne	12. Was Deceden	t Ever in I I S	13 1	Mac Decedent	2120	-	oifu Van ar Na	U.S.,	A .	can Indian
9	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other then "naturel", or items 23e or 28e-f show svent, the Mcdiral Examiner must be notified at	Funerai	1 XNever Married 2 Marrie	Armed Forces	?	1	Vas Decedent of f Yes, specify C			Rican, etc.)		ack, White,	etc.
003	urel', c	d by	3 Widowed 4 Divorced	Year or Dates			1 ☐ Yes 2 💢 1	No Speci	fy:		Speci	ity: Wh	ite
15-	in 72 h "nati	ojete	15. Decedent's (Specify only highest	grade completed)		(Give	lent's Usual Oc kind of work do DO NOT use rei	ne durina m	ost of workir	ng	16b. Kind of I	Business/In	dustry
21215-0036	filed with Hygiene. other ther	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		tomer Se	_ ′			Autor	nobili	2
pu	should be filed within to Mental Hygiene. marked other then metic svent, the Mental to Mental the Mental to Mental the Me	Be	17. Father's Name (First, Middle, La								Maiden Suma	me)	
Maryland	should be fand Mental I	To	Ferdinand J.  19a. Informant's Name/Relationshi	Soukup		10h 14-16-				t F.			
Ma	d 2 s th ar treu treu	1 3	Marlene Wooden	o (1908, Print) (siste	ותי		g Address (Stre Knoll						21234
re,	es 1 and 3 of Health fitem 27 ir other tr		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of		- water because	ate	20c. Location		
imo	Pages ment of I ant: If its ury or o		1 ☐ Burial 2 X Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		3	view (	remato)	ıy					Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Sign ture of Funeral Service Li	censee Ru	nek		Name and Add						2.5
Г			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause nly one cause on each	d the death. line.								Approximate Interval Between
	Pnysician /Medical	0	Immediate Cause (Final disease or condition resulting in death)	a. CHROI	VIC	OBST	RUCTI	WE,	PULI	YONA	RY		Onset and Death
ı	Examiner			NICE	s a conseque	ence of):	10 8	7467					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a conseque	ence of):		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
V	ecuted and -transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	ate be executed hysician and the burial-transit	ai E		Due to (or as	s a conseque	ence or):							
9	the the	ledicai		d					12				
Вох	death certific e attending p od for use as f	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregna	ncv				ate of delive	,
0.	the s	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of dea	ath 5□	Other (specify)				M	onth	Day Year
σ.	s that the	by Ph	Part II. Other significant condition	s contributing to death	but not result	ting in the ur	derlying cause	given in Par	t I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
rds	law requires that as been signed b 2 should be deta									1 🗆 Y	es 2 🗆 No	3 🔀 Prob	ably 4 Unknown
Vital Records,	e law requ has been je 2 shoul	ompieted								24a. Was a		Were auto	psy findings available inpletion of cause of
al B	Th ate pag	O								perfor	med?	death?	2□ No
Vit.	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospital:	ingt 2006	R/Outpatien	27704	Tab man		Check on or			
J of	ig Phy ter this neral c	-	27. Manner of Death	28a. Date of Inj.	ury 2	28b. Time of Injury	28c. In				ence 6 🗆 Otl ow injury occur		/)
sior	Attending I ir death. ector: After by the funer	catlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion	, , sui,	inquiy		Yes 2[	□No				
Division	or Dir	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place of in	jury - At hom tc. <i>(Specify)</i>	ne, farm, stre	et, factory, offic	9	2	8f. Location (S City or Tow	treet and Numi n, State)	ber or Rura	l Route Number,
	spite ours serel filled		29a. Certifier 1⊠ Certifying	Physician: To the best	of my know	ledge, death	occurred at the	time, date a	and place, a	nd due to the c	ause(s) and m	anner as st	ated,
	To the Hos within 24 h To the Fur completely	ledicai	(Check only 2 Medical Ex	aminer: On the basis of and manner s	of examination	on and/or inv	estigation, in m	y opinion, de	eath occurre	d at the time, d	late and place,	and due to	the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	Hash	m.l	MD		ense number			19d. Date signe		
,	141	-	30. Name and address of person wh	no completed course of			2				31-21		
	$\varphi$		SHER A HAS	HMI 390	00 LO	CH K	AVEN	BLU	OB,	ALTIA	10RE1	40.	21218
	Sta	-	31. Date filed (Month, Day, Year)	32 Regist	rar's Signatu					<del>-</del>			
	Registr	ar	JAN 2 5	2007 Secret	Red Sign								

Amend #19a&b Per Ana Bd G863 I 30/07 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Kenneth E. Smith JANUARY 18, 2007 5:40 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Feb 22, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1⊠M 2□F 218-22-0331 97 Director 1909 Maryland 田 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 23a or 28e-f show KENNETH treumatic event, the Madical Examiner must be notified at 10d. Inside City Limits MD Harford Havre de Grace 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 Deaver Street 21078 USA lteme 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: 135–38 3 X Widowed 4 ☐ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If itam 27 Ie marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) 12 paint technician 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Arthur D. Smith Haidee T. Tozier 19 (Type, Print) 19t802ngBrad1ey aRoader or Toppa AMDer 21085wn, State, Zip Code) Beverly Dahl/daughter Havre de Grace, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Licensee Rnald S. Wade, State Anatomy Board 655 W. Baltimore Street NAME /Director 21201 Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LEUKEMIA UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. by Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day 5 Other (specify) P.0. detached the 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2√ No 1 ☐ Yes 2 🗌 No 1 Tyes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this c 1 ☐ Yes 2 X No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 🕅 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause s and manner as stated 29a. Certifier Medical Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27578 1-18-07 30. Name and address of person who completed cause of death (from 23a) (Type, Print) M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD. 21902 AVELINA HERNANDEZ, 31. Date filed (Month, Day, Year) 327 Registrar's Signature State

Registrar

JAN 2 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stephen Desales Startt State of Maryland / Department of Health and Mental Hygiene 1-For Statemend #5 Per Inf G865 3/21/10/Cattle Death Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3. Time of Deat Month Medical Examine Month Day January 19, 2007 Stephen D. Startt 0500 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Building 17H and Avenue G Perry Point Cecil 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 213 - 76 - 909 = 213 - 76 = 909 = 213 - 76 = 909 = 9Months Foreign Country) Maryland Davs Hours  $_{1}X_{M}$ 50 Dec 30, 1956

Director

28a-f show notified at once. hours after death with the Maryland or items 23a or

Itimore, MD 21215-0036

It Pages I and 2 should be filed within 72 hours after de remont of Health and Mornal Hygiene.

Transt I fitem 27 is marked other than "natural", or yor other traumatic event, the Medical Examiner. Baltimore, I permit Pages I and Department of Healt Important: If item or other

Physician /Medical **€xaminer** 

and attending physician requires that the death certificate be Box 68760, the : signed by the be detached Division of Vital Records, P.O. has been The law certificate the Hospital or Attending Physician: this After the Funeral Director: # within 22

Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Hurlock Yes 2 X No Director 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? 4326 Bawlah Road 21643 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black 1 X Never Married Armed Forces? 2 Marrier White, etc. Yes Yes, Give Year 79-183 Divorced Yes 2 X No specify. Specify: White ş 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed unk 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 welder 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Thomas Paul Startt Nina Marie Slaughter 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina Startt/mother 201 Brooklette Avenue Easton, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify: ature of Full ral Service Lic State Anatomy Board 655 W. Baltimore Street ade, Part I. Enter the discase, or complications that caused the death. Do not enter Baltimore. MD 21201 mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and a Carbon monoxide intoxication Immediate Cause (Final disease Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED #23a,27,28a-f perME. 2863. 1/31/07 TT 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy past 12 months? Fetal death Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other<sub>4</sub> 1 🗸 Yes ER/Outpatient 3 Nursing Home 5 ٩ Residence 6 V Other Scene 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28d Describe how injury occurred subject placed hose from tail pipe 28c. Injury at Work Certification: Natural Pending Yes 2 X No Fnd 1/19/2007 | Fnd 4:50 am 2 Accident Investigation to car window 3 X Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)Building 17H & Avenue G Perry Point, MD 28e Place of Injury - At home, farm, street, factory, office building, etc. Could not be determined (Specify) hospital grounds 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E January 20, 2007 30 Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registra

JAN 25

07-00351 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Larry W. Smith 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day January 12, 2007 1130 hrs **Medical Examiner** Larry W. Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rising Sun Cecil 407 Dodson Drive 5. Social Security Number unk 7. Age (In yrs. last birthday) If Linder 1 Year If Linder 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6 Sex **Funeral** Foreign Months Days Hours Min unk Director 1 X M 2 F Country <u>July</u> 23 1954 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 3IIV 10a State 10b County 1 Yes 2 X No or 28a-f show MD Cecil North East Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unk 104 Michigan Court 21901 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black 11. Marital Status unk Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married unk Yes Divorced If Yes, Give Year Yes 2 X No specify: 3 Widowed Specify: white ģ 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4 or 5+) unk Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. Penn Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify:in/state 21. Signature of F are ral Service Licentee 22. Name and Address of Facility Ronald Director State Anatomy Board 655 W. Baltimore Street implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Mixed alcohol and drug (cocaine and methadone) intoxication mediate Cause (Final disease Examiner condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Due to (or as a consequence of). Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last burial - transi and Physician/Medical XUNPENDED AMENDED the attending physician ed for use as the burial #23a,27,28a-f, perME, g863, 1/26/07 TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Day Year Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 1 V Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene ٩ 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Natural Yes 2 X No Pending To the Funeral Director: Fnd 1/12/2007 Fnd 11:25 am unk. 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 407 Dodson Drive 6 X Could not be Suicide determined (Specify) Rising Sun Found: private dwelling Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) Medical Examiney: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b.<sub>∧</sub>Signature and/ti 29c License number 29d Date signed (Month, Day, Year) e of cert O.C.M.E. January 13, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. 31 Date filed (Month, Day, Year) 32. Registrar's Signature State 2000 Registrar JAN 2 HVH II Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Adolph Gustav Siperek **JANUARY** 18 2007 10:30PM "/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min Oct 3, 1925 81 219-10-8647 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21234 USA 2611 B Putty Hill Avenue Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 N Yes 2 No If Yes, Give Year or Dates: 143-46 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 ☒ No Specify. Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be be nd Me tal Hellen Munski Adolph Siperek of Health and Me to Item 27 is mark of other traumatic ev Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.1 Department of Health an important: If Item 27 is any injury or other trau 21122 328 North Caroline Avenue Pasadena, MD Allen Siperek/son Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street rvice Licensee 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ears **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed and Due to (or as a consequence of) physician a s the burial-1 P.O. Box 68760. Physician/Medical as attending p IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy 4□Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 Tyes 3 Probably 4 Unknown 2 □ No page 2 should Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2/2/No certificate 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 2 ER/Outpatient 3 DOA 1 TYes 1 Inpatient ို After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending 5 Pending investigation 1 Natural 1 Tyes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of sertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nav 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and items 17,18,19b per fh 9864 2-5-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January **Physician** 2007 Anita 3:43 a M Sacca /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 10 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Yrs. **191**0 New York 128-28-4972 96 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Itame 23a or 28a-f ehow 1 ☐ Yes 2 ☐ No Maryland Prince Georges Laurel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15785 Haynes Road 20707 United States America deeth Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Item any injury or other traumatic event, its Medical Examinar once. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: Completed by 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carmelo Fabio Carmello Sacca Angelina Fabio Angelina Millio ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anthony Sacca/Son 15785 Hatnes Road Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1/19/2007 Catonsville, Maryland 21. Signature of Funeral Tvice Licensee 22. Name and Address of Facility Fleck Funeral Hom 7601 Sandy Spring Road Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MANY YEARS Immediate Cause (Final disease or condition resulting in death) **Physician** HYPERTENSIVE CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۵ BREAST CARCINOMA, DEMENTIA 3 ☐ Probably 4 🕅 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL FIBRILATION, MULTIPLE DECUBITUS ULCERS 24a. Was an autopsy performed? this cartificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No or Attending Physician: diractor, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Nnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending death. investigation М t ☐ Yes 2 ☐ No 2 Accident within 24 hours eftar death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D23181 MD 1/18/2007 7 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R.G. BHOJRAJ, M.D. 704 Gorman Ave. #T-1 Laurel, MD 20707

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State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 21, Patricia Joan Scavello January 2007 10:30P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 604 Maiden Choice Lane Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2X F Yrs. 577-32-7220 79 28, 1927 Director Washington DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No **Funeral Director** injury or other traumatic event, the Medical Examiner must be notified MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 604 Maiden Choice Lane 'natural", or items 23a 21228 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: Be Completed by White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Howell T. Branch Julia Charlotte Shoots Health and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ron Hay - Son 505 Woodside Road, Baltimore, MD 21229 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition T Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) West Arundel Crematory 1-23-2007 4 □ Donation Odenton, MD 21. Signature of Funeral Service 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine i or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Day 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by pertension 2 10 3 Probably 4 Unknown 1 ☐ Yes perlipidema Were autopsy findings available prior to completion of cause of death?

1 Yes 24a. Was an autopsy perform history s'escore 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes ≥ No Certification: To 28a. Date of Injury (Month, Day Year) 28b Time of Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Satural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D51018

DHMH 17 Rev 1/2001

State Registrar 3421

32 egistrar's Signature

Benson Ave. Suite 230 Baltimore MD 2(22)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2007

Douglas

31. Date filed (Month, Day, Year)

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Stem, Bub	altimore, Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28e-f show other treumatic event, the Madical Examinar must be notified at	To Be	Thomas		Stem		Mei	Shum		
-	ary	shou ind M mar umat	-	19a. Informant's Name/Relationship (	Type, Print)		Mailing Address (Stree	t and Number or Rural	Route Number, C	tity or Town, State, Zij	c Code)
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	Ball	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licer	1		22. Name and Addr	ess of Facility	A Gov	m. ZIII	<b>′</b> .
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		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C			s of examination and		time, date and place, an opinion, death occurred			
		To th within To th compl	Me	29b. Signature and title of certifier			29c. Licen	ise number		. Date signed (Month,	
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				30. Name and address of person who	completed cause	of death (Item 23a) (T		. 1/1 1	, /	1/ 1-1	, 21093
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			For State Registrar Amend Items 225, 27,	<b>1884</b> and <b>EPant</b> Cer	tificate of Deat	h Re	eg. No.C U U /	01914
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	Funeral Director		216-07-2862	Age (In yrs. last birthday)  89 Yrs.	Months Days Hours	er 24 Hrs. 8. Date of Birth (Month, Day, 12/30/19	Year) Coun	
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	or 28	Funeral Director	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Coun	try?
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Baltimore,	Pa ant Lry		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St. 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery cret ANSHE EMU (AITZ_CHA	natory or other place) NAH	1	BALTIMORE,	
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Service Licensee		Name and Address of Far REISTERS	<sup>cility</sup> SOL LEVINS STOWN ROAD - F	SON & BROS., PIKESVILLE,	
	Physician /Medical Examiner	in the	resulting in death)  Due to (or	rased the death. Do not ent th line.  The salar a consequence of):  as a consequence of):	Disers	16	4	Approximate Interval Between Onset and Death
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Vita	Physician: The rath certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	patient 2 ER/Outpatie	Other:	ace of Death (Check only on Nursing Home 5 Resident	_	(v)
ō	ding Phys h. After this funeral dii	J: To	<b>72</b>		f 28c. Injury at		ow injury occurred	y)
Division	ttending I death. stor: After the funer	Certification:	27. Manner of Death  Tentatural 2 Accident  28a. Date of Month 11/30		n 1 □Yes 2		fell out of	
i	or Atte	rtific	4 Homicide determined building	f injury - At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, office	28f. Location (S. Cibror Tow.	treet and Number or Rura n. State) <b>House Ct., l</b>	al Route Number <b>MD Pikesville</b>
B	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the base and manner	sis of examination and/or ir	h occurred at the time, date vestigation, in my opinion,	e and place, and due to the c	cause(s) and manner as s	tated.
	To the Compl	Me	29b. Signature and title of certifier		29c. License numb		29d. Date signed ( <i>Month</i> ,	
(	20)		30. Name and address of person who completed cause DR : wdah Mm	Rove, 75		in St. R	Persters	town, MI
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Re JAN 2 4 2007	gistrar's Signature	9			

Day Month Edward F. Thiem January 24, 2007 1:00 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Sept. 17, 1 Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days 015-03-8236 Director 91 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Marel Hygene. Important: If time 27 is and Mental Hygene. Interact is and Mental Hygene. and interact is a series of show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7110 Minstrel Way #123 21045 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: 2 Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Mechanical Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Thiem ဂ္ Sophia Skiba 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Agnes Thiem/Niece 4638 Doncaster Dr. Elliott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State January 27 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Timonium, MD 21. Signature of Europe Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ComplicA RONS Dementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ artery ditente 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 DOther (Specify) hospite 1 Yes 2 No ပို 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: # 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 24 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6101 Ni Charles S+ BARRIMORE MD 21204 Amon J. Uthwes m 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death

2. Date of Death

			1 - For State Registrar	State	of Marylar	-	artment of H		and Mer		giene /	2007	01916
-	Physici	an	1. Decedent's Name (First, Middle Louis J. Vi	o, Last) Ctor						Date of Dea Month	Day	Year	3. Time of Death
,	/Medic Examin	al	4a. Facility Name (If not institution		umber)		4b. City, Town, or	Location o		anuary		2007 County of Death	4:20 A M
	Examin	ei	Future Care	. •				imore				N/A	
	Funeral Director		5. Social Security Number 081-14-2666	6. Sex 1 M 2 □ F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day	Year) 1917	9. Birth Con PA	place (State or Foreign untry)
	pu s		Usual Residence of Decedent  10a, State 10b, County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Maryla	tor	Maryland N/A			•	altimore						1 X Yes 2 □ No
	vith the	Director	10e. Street and Number 3416 Juneway				10f. Zip Code	2121	3		10g. Citize	en of What Cor	
	ma 234	Funerai	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba			y Yes or No-	14	1. Race - Amer	ican Indian,
0000	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f ahow the Madleal Examinal must be notified at	by	1 ☐ Never Married 2 X Marr 3 ☐ Widowed 4 ☐ Divorced		2 □ No live		,	Specify:	, rueno na	an, etc.)	- 1	Black, White Specify: Wh	
2	72 ho	Completed	15. Deceden (Specify only highes		")	(Give	dent's Usual Occupa	durina most	of working			of Business/I	,
7	within ene than	ompi	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		DO NOT use retired GUMAN	"				sh Nati olic Ch	
anaz	be filed with tal Hygiene. d other than avant, Ize M	Be C	17. Father's Name (First, Middle,	1		1 0200	ggmari	18. Mothe	r's Name (F	irst, Middle,			
5		To	Joseph Vict 19a. Informant's Name/Relations			10h Mailin	ng Address (Street		phie	·		e Unkno	
2	s 1 and 2 should f Health and Mer ltam 27 is marke other traumatic		Norma Victor	(wife	2)	10.0	Juneway,				2121		p Code)
e,	iges 1 and of Heam		20a. Method of Disposition 1    1		20b.		sition (Name of natory or other place		Date	-	20c. Loca	ation - City or 1	Town, State
	Pages tment of tant: If it		4 ☐Donation 5 ☐ Other (S	pecify)	Ho		ss PNCC		/23/2				Maryland
g	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service	Cicensee		9	. Name and Addres	r Rd.	, Schi , Bal	munek timore	Fune , MD	ral Hon 21236	nes
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not ent	er the mode of dyin	g, such as	cardiac or re	spiratory ari	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.	on cry	Artery	DISEA	SE -					myour
	Examiner		Compositely list conditions	+ A .	viel	FISAI	lation						unknam
-	9d sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consec	quence of):							
	axecution and al-tran	Examiner	that initiated events resulting in death) Last	c	o (or as a consec	quence of):							
2/0/	eath certificate be executed attending physicien and for use as the burial-transit	dical		d							_		
X	certific ding p	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregn	ancy					23	ld. Date of deli	/ARV
C. BOX	The law requires that the death certificate be execut wie has been signed by the attending physicien and bage 2 should be detached for use as the burial-tran	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 ☐ Feto gnant at time of o nown		Ectopic pregnancy Other (specify)					Month	Day Year
ī.	that the	y Ph	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco use	e contribute to	the cause of death?
ecords,	n requires that the de been signed by the should be detached	ted by	Bilat dece	Vein	thromb	مدقح			[	1 🗆 Y	es 2□	No 3 ☐ Pro	bably 4 Unknown
Z Z	sician: The law r certificete has be irector, page 2 sh	Completed								24a. Was a autop: perfor	an sy ned? 2X No	death?	opsy findings available ompletion of cause of
VIII		0	25. Was case referred to medical					26. Place	of Death (C	1 ☐ Yes Check only or		1 🗀 Yes	2 No
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No			ER/Outpatien		Br: 🗚 Nur	rsing Home	5 🗆 Resid	ence 6	□Other (Spec	ify)
	ding P. h. Atter t	tion:	27. Manner of Death  1 ★Natural 5 □ Pendin 2 □ Accident investig		e of Injury nth, Day Year)	28b. Time of Injury	Worl	/at k? Yes 2 □ N		l. Describe h	ow injury	occurred	
DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could determ		ce of Injury - At h	nome, farm, str	eet, factory, office			Location (S City or Tow	treet and	Number or Ru	ral Route Number,
5	urs aft arai Di	Cer											
	na Hos	ledical	29a. Certifier   Certifyin (Check only one)   2   Medical	g Physicien: To the Examiner: On the and ma	ne best of my kn basis of examin nner stated.	owledge, death ation and/or in	r occurred at the time vestigation, in my of	ne, date and pinion, deat	d place, and th occurred a	at the time, o	ause(s) a late and p	nd manner as place, and due	stated. to the cause(s)
	To th Withir To th Comp	Me	29b. Signature and title of contifle	2			29c. License	number		4	9d. Date	signed (Month	, Day, Year)
	.1		1			MO		0590	56		1/2	2-107	
	4		30. Name and address of person	who completed cau		m 23a) (Type, Stors to		BC 1.	finere	MO	2	1215 (	SUITE 106)
	Sta		31. Date filed (Month, Day, Year)	32	Registrar's Sign	ature	mil	p-1	( ) ACT				
	Registr	ar	JAN 2 5	2007	Side of St.	J. AD	MEL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 20, 2007 1943 William Charles Wagner, Sr. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**∑**M 2□F Months Days Hours Director June 2, 1933 Pennsylvania 188-26-3316 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show in then "natural, or items 23a or 28a-f showing Madical Examiner a ust be notified at 1 ☐ Yes 2 X No Directo Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 21014 124 Chatham Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ 3 XWidowed 4 ☐ Divorced White marked other than natural, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 12th Grade Mechanic Pressman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental Elizabeth McClellan Martin Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: if itsm 27 is Cheryl Brockmeyer (Daughter) 124 Chatham Road, Bel Air, Maryland 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 01/22/2007 Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Rd. Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, feeding to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Wagner William Brision of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to compfetion of cause of death? 24a. Was an autopsy 2**X** No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check only one examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) fnpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending after death. 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01-21-2607 30. Name and address of person who compfeted cause of death (ftem 23a) (Type, Print) Belain, MD 21014 31. Date filed (Month Day, Year) hesapeake 32. Registrar's Signature State Registrar

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			For Stata Registrar	State of	f Marylan		artment of H				jien <del>)</del> () (	7	01918
	Physici	an	1. Decedent's Name (First, Middle							Date of Dea Month	Day	Year	3. Time of Death
	/Medic		BARBARA	WIL						9 Nuary		007	9:20AM
	Examin	er	4a. Facility Name (If not institution	-			4b. City, Town, or			•	4c. County		
			NORTH WEST  5. Social Security Number		CENTER 7. Age (In yrs. )	last hirthday)	RANDAL:	LSTOW		Date of Birth		I MORE	E place (State or Foreign
	Funeral Director		212-30-4260	1 □ M 2 🖫 F	90-1	4 Yrs.	Months Days	Hours	Min.	(Month, Day	, Year)	Cou?	TLAND
			Usual Residence of Decedent			-			, pc	1. 1/	1772	LIMIT	, LIAND
	how		10a. State 10b. County		10c. City	y, Town or Lo	cation					1	10d. Inside City Limits
	B Ma-fs	cto	MARYLAND N/	'A			BALTIMOR	E					1XXYes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
	ath w		1107 N LONGWO				2121				U.S.A.		
	tems	Funeral	11. Marital Status	Armed Fo	dent Ever in U. rces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Specify n, Puerto Rica	Yes or No- in, etc.)	14. Rad Bla	ce - Americ ck, White,	ean Indian, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ★ Divorced	ied 1 ☐ Yes If Yes, Giv Year or D	/e		1□Yes 2KDX⊌o	Specify:			Specif	y: BLAC	CK
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	edt	15. Deceden		ates.	16a Dece	dent's Usual Occup	ation			16b. Kind of B		
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פַ	a filed it Hygie other	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (Fi	rst, Middle,	Maiden Sumar	ne)	
aryland	Aenta Aenta rked ric e	To E						MA	RTHA C	ANN			
a	es 1 and 2 should be fi of Health and Mentat H litem 27 is marked ot r other treumatic ever		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rural Ro	oute Number	r, City or Town,	State, Zip	Code)
Σ	and alth		Barbara L. Wil	son/Daugh			Longwood	St.,			Marylan		
ore	of H		20a. Method of Disposition  **Example 1.1	3 □Removal from		lace of Dispo emetery, crei	sition (Name of matory or other plac	ce)	Date		20c. Location	City or To	wn, State
altimore,	Pages ment of lient: If its		`4 □Donation 5 □ Other (S	pecify)		NG MEM	ORIAL PAI	RK	01-27-	07	BALTIM	ORE,	MARYLAND
Ba	permit. Pages 1 a Department of Hea Importent: if Item any injury or othe		21. Signature of Funeral Service Licensee  22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL 1206 W NORTH AVENUE									L HOM	E P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								est,		Approximate Interval Between
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<u>~</u>	: The	Co	PNEUN									death? 1 ☐ Yes	2 🗆 No
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ot	Phys this ral dir	- T	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o	IL 3000	4 🗀 140	-		ence 6 Oth		у)
O	ding I h. After funer	tion	1 Patural 5 Pendir 2 Accident investi	ng (Mon	th, Day Year)	Injury	Wor	k? Yes 2□			,.,		
Division of Vital Records,	f or Attending Physicien: after death. Director: After this certifics in by the funeral director. I	fica	3 Suicide 6 Could	not be 28e. Place	of Injury - At ho	ome, farm, str	eet, factory, office		28f.			per or Rura	al Route Number,
á	el or A s after il Direct	Certification:	4 Homicide	buildi	ng, etc. (Specif)	Y)				City or Tow	n, State)		
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate h completely filled in by the funeral director, page	edical (		ng Physician: To the Examiner: On the b									
	Fo the within Fo the comple	Me	29b. Signature and title of certifie				29c. Licens	e number		2	9d. Date signe	d (Month,	Day, Year)
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	, (		30. Name and address of person	who completed caus			Print)						
	7		KAZU UMA	210 B	UMNES	S CEN	VTER DR	WE F	28159	ERST	own,	MD	2-1136
	Sta		31. Date filed (Month, Day, Year)	32	legistrar's Signa						,		
	Registi	ar	IAN 2 5	2007	allenge of the	The Co	BARL!						

	1 - For State Ragistrar	State of Maryla	•	artment of H			giene Reg. No.	7 01919
Physician /Medical Examiner	Decedent's Name (First, Middle, Las     Charles E     4a. Facility Name (If not institution, give	dwin Wilki	e, Jr.	4b. City, Town, or	Location of D	2. Date of De Month  Januar  Peath	Day	Year 007 4:34 P Moof Death
Funeral	614 Warren Road 5. Social Security Number 6. Se	VIM 2FIF	. last birthday) Yrs.	Cocker If Under 1 Year Months Days	75Ville If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da	th ly, Year)	imore  9. Birthplace (State or Foreig Country)
Director	Usual Residence of Decedent  10a. State  10b. County	/4	City, Town or Lo	ocation		Feb 11	, 1932	Pennsylvania  10d. Inside City Limits
3a or 28a-feat be rutified	Maryland Baltimo  10e. Street and Number  614 Warren Road	re	Cockey	10f. Zip Code 210	30		10g. Citizen of W	,
Hygiene. wher then "netural, or items 23s or 28s-1 show ant, the Medical Exeminer must be nutified at a Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:				? (Specify Yes or No uerto Rican, etc.)		e - American Indian, k, White, etc.
th and Mental Hygiene. 7 is marked other than "natural", traumatic event, Ira Madical Ear To Be Completed by	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	ucation de completed)  College (1-4or 5+)  n/a	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of )	working	16b. Kind of Bu	,
and Mental Hygiene. Is marked other than raumatic event, Ins Mi	17. Father's Name (First, Middle, Last)  Charles Edwi	n Wilkie			18. Mother's Elsi	<del></del>	, Maiden Sumam Jutter	9)
Department of Health and Important: If Item 27 is meny injury or other traum once.	19a. Informant's Name/Relationship (7  Jeffrey C. Wilkie  20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	/ Son 20b. Removal from State	32 ( Place of Dispondential Commentary, cress 11aney	Camellia ( osition (Name of matory or other plac Valley Me	Court,	Baltimore Date 22/07 Gardens	Maryla 20c. Location	
Departi Import eny inj once	Lowell M. Lemm 23a. Part1. Enter the disease, or comp	on			neral H onia Ro			11ey Inc. 21093
ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Inhalation of Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.	equence of):	blower exh	oust fu	umes -Su	icide	Onset and Death
ed by the attending ph detached for use as th y Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery ath Day Year
be d	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	inderlying cause give	en in Part I.			ibute to the cause of death?  3 Probably 4 Munknow
page 2						1 ☐ Yes	propried? d 2 No 1	Vere autopsy findings availab rior to completion of cause of eath? ☐ Yes 2 ★ No
fter this ineral di on: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Sussicide 6 Could not be	28a. Date of Injury (Month, Day Year)  Sanuary 18, 2007  28e. Place of Injury - At	home, farm, st	28c. Injun Work	er: 4 □ Nursir	Saicide	dence 6 Other	tion exhaus T fum
within 24 hours after death. To the Funeral Director: A completely filled in by the tu Medical Certificati	29a. Certifier (Check only)  2 Medical Exem	building, etc. (Specification)  Signification: To the best of my kniner: On the basis of examination	<i>cify)</i> <b>≩</b> nowledge, deat	h occurred at the tin	ne, date and p	lace, and due to the	cause(s) and mai	nner as stated.
vithin 2- To the Complete	29b. Signature and title of cyrtifier	and manner stated.	at v	29c. Licenso	number		29d. Date signed	(Month, Dey, Year)
State	30. Name and address of person who of Philip Militella (Month, Day, Year)	completed cause of death (Ite	ble H	Print)		ile, Md		1

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** ROBERT WELLS JANKARY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE Year | If Under 24 Hrs. 8. [ N/A JOHNS HORKINS BAYVIEW MEDICAL CEMEN 6. Sex 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min. 14, Director 214-50-5661 Dec. 1949 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2805 McComas Avenue 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ White 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Diportant: If tiem 27 is marked other than "natuu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 12 years Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert S. Wells Ilona R. Racy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 McComas Ave. Veronica J. Wells Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 1/24/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Avenue Home of Dundalk, Inc. Dundalk, Maryland 21222 23a. Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus Final Physician RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner LUNG CANCER NON SMALL CELL Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autops, performed os 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manna of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: al or Attending F after death. I Director: After 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10

31. Date filed (Month, Day, Year)

JAN 2 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

ARRESTERN AVENUE BAUTIMORE, MD

DHMH 17 Rev 1/2001

State

Registrar

ES-000

Physician
*/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

State
Registrar

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 21 2007<sup>ear</sup> 6:05 p M William R. Worth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 9.28 -1934 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 219-30-3823 1√2 M 2 □ F 72 MD Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 No Director Baltimore Dundalk 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7832 Rockbourne Road 21222 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1955 1 ☐ Never Married - 2 ☐ Married 1 ☐ Yes 2 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellie E. Worth Eva L. Trayer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Emily Worth - Wife 7832 Rockbourne Road, Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory 1-23-07 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton Funeral Home PA, 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): STAPH AUREUS / PROTEUS MIRABILIS 3 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown CHRONIC KIDNEY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an HYPERTENSION 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) enebal D0044018 January 22 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
EUGENE A OBAH, MD 6701 N CHARLES ST TOWSON, MD 21204 32 Registrar's Signature 31. Date filed (Month, Day, Year) JAN 2 5 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear Selma Gorin Abramson 10:00 P.M 5, 2007 January 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 5802 Nicholson Lane, Apartment # 804 Montgomery Rockville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 577-84-1035 May 30, 1919 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County Yes 2 No Maryland| Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5802 Nicholson Lane, Apt. # 804 20852 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ♣ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry

Physician

/Medical

Examiner

10a. State

Elementary/Secondary (0-12)

Director

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**Funeral** 

Director

**Physician** /Medical Examiner

The law requires that the death certificate be executed burial-trar nding physician a use atten for u ed by the a signed be det cate has i certificate this

Box 68760,

P.0.

Division or Vital Records,

21. Signature of Funeral Service License Donald 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Brain Tumor disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or righry that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> Completed 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 2 1 Inpatient After thi 27. Manner of Death 1 Natural To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 28a Date of Injury 28h Time of 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier MID 53177 lame an address of person who completed cause of death (Item 23a) (Type, Print)

John Wallmark, M. D. 9707 Medical Center Drive, Rockville, Maryland

32. Rajistrar's Signature

Completed College (1-4or 5+) 3 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Mogul Jean Fuchs မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Gorin, M. D. Son 39 Lasalle Avenue, Piedmont, California 94611 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem, Gdns 1/9/2007 Falls Church, Virginia 22 Name and Address of Facility
Edward Sagel Funeral Direction,
1091 Rockville Pike, Rockville, Inc. Maryland Approximate Interval Between Onset and Death Chronic 23d. Date of delivery Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed? 2**X** No Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) January 7, 2007 20878

State

Registrar

31. Date filed (Month, Day, Year)

10

2007

			1 - State of Maryland / Dep  Registrar  Ce	artment of Health and Mertificate of Death	lental Hygi	g. No.	01923			
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	) 5 2007	3. Time of Death			
	/Medic	al	Thomas Francis Bradshaw, Jr.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	01 (	4c. County of Death	8:40p M			
	Examin	er	William Hill Heath Care	Easton		Talbot				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	ł	place (State or Foreign			
	Director		051-14-9303   ¹XM 2□F   90 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 10 - 21 - 1	916 Bro	oklyn,NY			
	pu .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	castian			and Inside Challenia			
	shoved	ក	Md Talbot Easton	ocation			10d. Inside City Limits  TV□ Yes 2 □ No			
	the N	ect	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou				
	a or	٥	545 Cynwood Drive	21601		USA	nay:			
	death ms 2	Funeral Director		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer				
ø	after or Ite	Ē	1 Never Married 2 Married 1 Xes 2 No	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	Hican, etc.)	Black, White				
003	urel',	d by	3X Widowed 4 □ Divorced Year or Dates Army	TEL 165 ZEANO Specify.		Specify: Wh	ıte			
- <del>2</del>	within 72 hours after death with the Maryland ene. Then "neturel", or Items 23a or 28a-f show The Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ring 1	6b. Kind of Business/Ir	CO.			
7	withi ene. then	шо	Elementary/Secondary (0-12) College (1-4or 5+)			Point Pet	er Block			
<u>0</u>	filed Hygid other ent,	Be C	12 years 3 years Pre	sident 18. Mother's Name	e (First, Middle, M	laiden Sumame)				
<u>lan</u>	should be filed within 72 hours after death with the Marylan nd Mentral Hygiens in marked other then "neturel; or Items 23a or 28a-f show marked other then "neturel; or Items 23a or 28a-f show matic event, the Medical Examinat must be notified at	To B	Thomas F. Bradshaw	Mary M	lcDonoug	jh				
Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury or other treumatic. <u>once.</u>			ing Address (Street and Number or Run						
	and ealth m 27 her tr			20 Arirang Way,						
altimore,	Pages 1 nent of H ent: If ite ury or otl		T Dunar 2 Defination 3 Dramovarion State	ematory or other place)		Oc. Location - City or T				
Ë	t. Pa rtmen rtent: njury			Crematory   1-8-		over, De				
Ba	permit. Departr Importe any inji			R. Carrolf Hurl						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	P.O. Box 518 St	or respiratory arre	els, Md.	21663 Approximate			
	nysician /Medical		shock, or heart failure. List only one cause on each life. Immediate Cause (Final	tion Preum	4	.	Interval Between Onset and Death			
			disease or condition resulting in death)  a. Due to (or as a consequence of):							
	Examiner		Dung		6 mis					
	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	8:00 0			4			
	ecute and trans	Examiner	that initiated events resulting in death) Last  C.  Due to (or as a consequence of):	Dra Alyberne	5 4pe		18hh			
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal E	Due to (or as a consequence or).	/	•					
687	physics the		d							
Вох	leath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	erv			
m	death e atte	Physician/Med	in the past 12 months?  1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year			
P.O.	at the by th stache	hys	9 Unknown							
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oro	w requir been si should	ted			1 L Yes	s 2.00√No 3Pro	bably 4 Unknown			
Records,	has b	Completed			24a. Was an autopsy	✓ ✓ prior to co	opsy findings available impletion of cause of			
a	n: Th icate r, pag				perform 1 ☐ Yes 2	□ No 1 □ Yes	2 🗆 No			
<b>=</b>	sicier	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Mo  Hospital: 1 ☐ Inpatient 2 ☐ EP/Outcatie	Other	h (Check only one					
o	Attending Physicien: r death. ector: After this certifics by the funeral director, i	-	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how	nce 6 Other (Speci w injury occurred	(y)			
<u>o</u>	nding ath. r: Afte e fun	atlo	1   Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No						
Division of Vital	r Atte er de recto	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rui State)	al Route Number,			
	itel or rel Dire									
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: Atterthis certificate h completely filled in by the funeral director, page	Medical	29a. Certifier 1 ✓ Certifying Physician: To the best of my knowledge, dea (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurrence.	and due to the car red at the time, da	use(s) and manner as t te and place, and due t	stated. o the cause(s)			
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)			
	F 3 F 8		Welleam Hala Mai	D0871	_	1/6/0-	7			
			30. Name and address of person who completed cause of death (Ite n 221) (Type	, Print)		,010/				
57	-1VA-		William H. Wood, Jr. MD 50	•	e, East	on, Md.21	601			
	Sta		31. Date filed (Month, Day, Year) 22. Registrar's Signature		-					
	Registi	ar	JAN 0 8 2007							

			1 - For State Registrar	State of	f Marylar		artmen				, ,	jiene og. No./	2007	01924
			Decedent's Name (First, Middle, La	st)					-		Date of Dea	th		3. Time of Death
	Physici			HATTIE	LAURA	AURA BENDER					Month January		2007	10:55 P M
,	/Medic Examin										andary		County of Deat	
	Exami	lei		Northampton Manor Nursing Home Frederick									Freder	
	Funeral		Social Security Number 6. 8		7. Age (In yrs.	last birthday)	If Under			24 Hrs. 8.	Date of Birth	1	9. Birt	hplace (State or Foreign
	Director		219-20-0205	M 2GF	8.	**	Months	Days	Hours	Min.	(Month, Day eb. 13	, Year) 19	9. Birt Co 21 Mary	vintry) \
			Usual Residence of Decedent					l						
	show		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	a-f.s	cto	Maryland Frederic	ck		Frederi	ick							1 X Yes 2 ☐ No
	다 다 28	ire	10e. Street and Number				10f. Zip	Code			1	0g. Citiz	zen of What Co	ountry?
	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or iteme 23a or 28a-f show int, the Medical Exertical must be indiffed at	Funeral Director	252 East 7th Stre	eet				2170	01			U	S.A.	
	dea F	ner	11. Marital Status	12. Was Dece Armed Fo	ident Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Ori	igin? (Specif	y Yes or No- an, etc.)	1	14. Race - Ame Black, Whit	
9	or it	5	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes If Yes, Giv	2 X No		1 ☐ Yes 2				u., 0.0.,		Specify:	0, 010.
21215-0036	ours	d by	3 X Widowed 4 □ Divorced	Year or Da	ates:				оросу.				V V	Vhite
5	72 h 'natu	Completed	15. Decedent's E (Specify only highest gra			(Give	dent's Usua kind of wor	k done d	lurina mos	at of working		16b. Kir	nd of Business/	Industry
21	of thin	du	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT us					~ -		
2	ygie her ti		0			2	Seamst	ress			***			Factory
ī	2 should be filed withlr and Mental Hygiene. Ie markad other then aumatic event, the Ma	Be	17. Father's Name (First, Middle, Last Oscar H. Michael	,							First, Middle, . Vachtei		Sumame)	
7/8	should be t and Mental H markad of	Ç												
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryle It of Health and Mental Hygiene If Item 27 is marked other then "naturel", or Items 23a or 28a-f show or other traumatic event, the Madical Exertical must be codified at		19a. Informant's Name/Relationship	,, ,									Town, State, 2	Zip Code)
	1 and Health Iem 27 other tr		Gloria Kelly / Da	augnter	20h	Place of Dispo			ourt,	Smltr Date			21783	T O
9	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from	State	cemetery, crea	matory or o	ther place				20c. Lo	cation - City or	Town, State
Ë	men tant:		4 □Donation 5 □ Other (Speci		Mt	. 01ive			-					Maryland
Baltimore,	permit. Pages 1 and in Dapartment of Health important: If Item 27 any injury or other troops.		21. Signature of Funeral Service Lice	S€0		RC	BERT	d Addres E . I	S of Facilit	¥ & SC	ON, FUNI	ERAL	HOMES,	P.A.
	70 = 4 0		Kante . De	341		12	ZUI NU	KIH	MARK	EI SI.	, FREI	DEKT	CK, MD	21/01
			23a. Part . Enter the disease, or com shock, or heart failure. List only	one cause on e	aused the dea ach line.	th. Do not ent	ter the mod	e of dying						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	, Co	nees	tive	1-	ear	- f	aili	we			Home
	/Medical Examiner		resulting in death)	Due to (	or as a consec	quence of):	n	.1		M	we vsee			
	Lxammer		Sequentially list conditions,	b	oron	m	1	Vtc	ry	\	voce	~		year
	P 16	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a consec	quence of):								/
	and -tran	cam	that initiated events resulting in death) Last	C. Due to										
60,	ate be executed hysicien and the burial-transit	E E		Due 10 (	or as a consec	(uence or).								
8760	icate be executed physicien and s the burial-transIt	dicai	•	d							-			
9 ×	E 0 0	₩.	IF FEMALE:	00- 14	va e Mrchin I									
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 Feta	al death 3	Ectopic pr					2	23d. Date of del Month	ivery Day Year
	the a	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregn 9☐Unkno	ant at time of o	death 5	Other (sp	ecify)						
P.O.	thet the daath cer ed by the attendir detached for use	Ph)		anatabutia a ta' da	ath hut not so	and the same of the same of			in to Do at		02a Did to	<b></b>		
S,	signe d be c	Ď	Part II. Dther significant conditions	continuousig to de	au out not 19:	sulling in the u	nderlying ca	ause give	en en Patti					the cause of death?
oro	w require	Completed									1111	es 2	_ NO 3 _ FI	obably 44 Unknown
ec	law les b	pje									24a. Was a autop:	sy	prior to	topsy findings available completion of cause of
	The sete he paga	် ပြ									perfor 1 ☐ Yes	med?	death?	2 □ No
ïta	artific octor,	Be	25. Was case referred to medical examiner?						26. Place	e of Death (C	Check only or	18)		
of Vital Records,	Physicien: this cartific ral director,	ပ္	1 ☐ Yes 2 No			ER/Outpatier	nt 3 DO	A Othe	97. 400 NL	ursing Home	5 🗆 Resid	ence 6	6 □Other (Spe	city)
n	5 6		27. Manner of Death  1/≰Natural 5 □ Pending	28a. Date (Mont	of Injury th, Day Year)	28b. Time o Injury	f 2	8c. Injury Work	at	280	Describe h	ow injury	y occurred	
sio	Attending in death.	cat	2 ☐ Accident investigation				М	1 🗆 \	Yes 2□	No				
Division	or Att	Certification:	3 Suicide 6 Could not to determined	286. Place	of Injury - At h ng, etc. (Speci	iome, farm, str fy)	reet, factory	, office		28f	Location (S City or Tow	treet and n, State	d Number or Ri )	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu													
	Hosp 4 hou Fune ely fi	edicai	29a. Certifier 1 Cartifying P	miner: On the b	acis of examin.	owledge, deat ation and/or in	h occurred vestigation,	at the tim in my or	ie, date an	nd place, and ath occurred	due to the o at the time, o	ause(s) late and	and manner as	stated. to the cause(s)
	the the the the the the the the the the	Med	une)	nd mani	ner stated.	Al al				- 18				
	or ¥ co		29b. Signature and title of certifier	1			f		1309	3.1			e signed (Mont	
			<b>/</b>	8/				الع	1,507	' (		/	1-9-0	/
/	Q		30. Name and address of person who	_ ~ / .	e of death (Ite	т 23а) (Туре,	Print)	T	16	11-	. 1	10	1	7 Levich M
				laid!		oturo.	001	40		mous	e Hi	re,	tres	cerich FU
	Sta	ate	31. Date filed (Month, Day, Year)	007	egistrar's Sign	H. A	racks							

			For State Registrar		Sta	ate of M	aryland		artment tificate		ealth and Death	d Menta		iene	007	01925	
			1. Decedent's Nam	ө (First, Middle	, Last)								te of Deat	h Day	Year	3. Time of Death	
	Physicia /Medic		John	C. B	aker								>1	10	07	0110 AM	
	Examin		4a. Facility Name (	_	1		1		4b. City, To	own, or	Location of De	ath		1	unty of Death		
			Atlantic	c Gene	ral H	Ospita	١		Be.	11/	~, MO	)		W	orcest		
	Funeral Director		5. Social Security N 217-22-93		6. Sex 1 2 M 2		ge (In yrs. Ia 91	ast birthday) Yrs.	If Under 1 Months	Year Days	Hours M	in. 8. Da ( <i>M</i> 0	te of Birth onth, Day, 18	<sup>Year)</sup> 191	Cou	place (State or Foreign ntry) D	
	<b>E</b> *		Usual Residence of	of Decedent 10b. County			10c City	. Town or Lo	pation							10d. Inside City Limits	_
	anyta ehov	_					1		Cation							1- Yes 2 No	
	r 28e-f ehow	Director	MD 10e. Street and Nu	Worce	ester		Ber	lin_	10f. Zip C	`ada			1	Og Citizer	n of What Cou		_
	with	급													101 11111111111111111111111111111111111	inty:	
	death w	era	10948 S	st. Mari		d • as Decedent	Ever in U.S	S. 13.1	2181 Was Decede		ispanic Origin?	(Specify Ye	es or No-	USA 14.	Race - Ameri	can Indian,	_
	ter d	Funeral		ried 2 Marr	Ar	med Forces	?	10.1	f Yes, specif	y Cubai	n, Mexican, Pu	ierto Rican,	etc.)		Black, White		
38	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28e-f show he Modical Examiner mout be notified at	þ		4 Divorced	lf '	Yes, Give ear or Dates:			1 ☐ Yes 2	No.	Specify:			Sp	vecify: Whi	te	
ŏ	72 hours "natural"	Completed	/0	15. Deceden				16a. Dece	dent's Usual	Occupa	ation	undring		16b. Kind	of Business/Ir	ndustry	_
215	hin 7	ple	Elementary/Sec	cify only highes ondary (0-12)	Ť	ollege (1-4or	5+)	life.	DO NOT use	retired,	during most of ( i)	WORING					
2	gieni gieni	Son	12	, , ,				Fai	rmer						chery		_
g	al Hygid d other event, Il	Be (	17. Father's Name								18. Mother's I						
<u> </u>	should be nd Mental marked c	2		Wilbu								Eliz					_
Maryland 21215-0036	2 sh and ie m		19a. Informant's N			rint)		1	,		and Number or					p Code)	
<u>~</u>	and fealth m 27			Baker	(son)		20h P	10948			tins Rd	., Be			21811 tion - City or T	our Ctato	_
ore	Pages 1 nent of H int: If ite		20a. Method of Dis	sposition	3 □Remov	al from State	C	emetery, crei	matory or oth	er place	1						
Ë	tmen tent:			5 Other (S			Ri	versi				2/200			rtytow		
Baltimore,	permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neary injury or other treumatic event, the Macanone.		21. Signature of F	Service	Sub	ر رہ			2. Name and )8 Wil.		m St.,		_	-	neral : 11	Home	
			23a. Part1. Emer shock, or he	re disease, or art failure. List	complication	ns that cause se on each	d the death	. Do not ent	er the mode	of dying	g, such as card	diac or resp	ratory arr	est,		Approximate Interval Between	
	Physician	`	Immediate Cause disease or conditi	(Final		SERS										Onset and Death	
	/Medical		resulting in death)		( a	Due to (or a		uence of):	. 0	!							-
	Examiner		Sequentially list c	onditions.	b	urir	and	tract	inted	7001							_
Ollo	it of	iner	if any, leading to it cause. Enter Und	mmediate leriving	2	Doe to (or a	s à unne de	uence of):									
2.4	ficate be executed physicien and sthe burial-transit	Examiner	Cause (Disease of that initiated even resulting in death)	ts	c	Due to (or a	s a consecu	ience of):									_
700 8760,	be ey	a E				500 10 (01 0	5 G 50115541	30.100 31).									
788	phys phys	dical			d										11		
/2 L ×	eath certif ettending for use a	/We	IF FEMALE:	-11	23c. If	yes, outcom	e of pregna	ncy						230	d. Date of delin	/Arv	
20 B	wrequires that the death certificate of the strength of the ettending should be detached for use as	by Physician/Me	23b. Was decede in the past 1:	2 months?	1	Live birth	2 🗌 Fetal	death 3	☐Ectopic pre☐Other (spe		,			250	Month	Day Year	
<u>%</u> ₹ 0		isku	1 ☐ Yes 2 9 ☐ Unknow			Unknown				//							
K	ires that signed b	y P	Part II. Other sign	ificant conditi	ons contribu	ting to death	but not resi	ulting in the u	inderlying ca	use give	en in Part I.	2	3e. Did to	bacco use	contribute to	the cause of death?	
POP. POP. Ords.	quire on sig uld b	pe pe										_	1 🗆 Y	es 2 🗆	No 3□Pro	bably 4 Minknown	
Pon Pon Records	The law requires that the tte has been signed by the bage 2 should be detache	Completed										2	4a. Wasa		24b. Were aut	opsy findings available	
_ &	The lav	E										_	autops perfori ☐ Yes	med?	death?	ompletion of cause of 2 No	
ita C	ician: Th certificate ector, pag	0	25. Was case refe	erred to medica	l l						26. Place of		The same			22410	
マグラ	nysic lis ce direc	To B	examiner?	No	Hospit	tal: 1 🖒 Inpat	tient 2	ER/Outpatie	nt 3 DOA	Oth	er: 4 🗆 Nursin	g Home	5 🗌 Reside	ence 6[	☐Other (Spec	ufy)	
13.50	ding Ph I. After th funeral	Ë	27. Manner of Dea	ath 5 ☐ Pendir	28	Ba. Date of In (Month, D	jury lay Year)	28b. Time of Injury	of 28	c. Injun Worl	y at k?	28d. C	escribe h	ow injury o	occurred		
Sio	ttendii death. stor: Ai	Satio	2 Accident	investi	gation				М		Yes 2 □ No						
1, 200	or A after Dire	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ		Be. Place of In building,	njury - At ho etc. <i>(Specif</i> )	ome, farm, st //	reet, factory,	office			ocation (Sity or Town		<b>Number</b> or Ru	ral Route Number,	
3 mg	Hospital 4 hours a Funeral		29a. Certifier	1 Certifyin	ng Physician	n: To the bes	at of my kno	wiedge, dear	th occurred a	t the tin	ne, date and pi	lace, and du	ue to the c	ause(s) ar	nd manner as	stated.	
30	n 24 i n 24 i he Fu	Medicai	(Check only one)	2	Examiner: (	On the basis and manner t	of examina stated.	tion and/or in	ivestigation,	in my o	pinion, death o	occurred at 1	the time, d	late and p	lace, and due	to the cause(s)	
	To the To the Comp	Σ	29b. Signature an	nd title of certifie	man	nd M	n		29c.	License	e number		2	29d. Date :	signed (Month	, Day, Year)	
			M	vari 9	MIVIO	81111	P			DC	10563	307		Janu	round 1	U, 20U+	
	6A3		30. Name Vd ad	dress of pers of	this comple	oted cause of	death (Item	GC/142	Print)	tal,	9783	itealth	hnay	Dr.	Berlin	, MD 21811	
	Sta Regist		31. Date filed (Mo	JAN 1	1 2007	32. R Sis	trar's Signa	iture,	Sports	,						, Day, Year) 0, JOU7 , MO 2/8/1	_
																	_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Shandara Ayelle Bolden 12:30 P<sup>M</sup> January 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bayside Care Center Lexington Park St. Mary's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs Director 241-29-3287 30 11/12/1976 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2 TNo Director Maryland St. Mary's Piney Point 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code tem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 46048 Sheaffer Lane death v 20674 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 XYes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Aide <u>Healthcare</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental Willie Richardson ပ္ Daphne Ruth Bolden 19a. Informant's Name/Relationship (Type. Print) Foster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Patricia A. Radcliffe/Mother P.O. Box 87 Piney Point, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important; If ite any Injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem;01/17/2007 Cheltenham, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M0120622955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician arcint /Medical Examiner Sequentially list conditions, if any, leading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 M No been signed by the should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No Hospital or Attending Physician; After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 5 Pending investigation 1 💀 Natural afer death.

I Director: A
d in by the fu 1 Tes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a 29a. Certifier 1 🛢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

emes

Jarboe, M.D.

30. Name and address

31. Date filed (Month, Day, Year)

James P.

person who completed

1 6 2007

24035 Three Notch Road, Hollywood, Maryland

ause of death (Item 23a) (Type, Print)

			1 = For Stete Registrer	State of Maryland /		tment of He			ene g. No 2007	01927
	<b>I</b> I		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medic		Rose Leona	Bradburn				Ol	17 2007	1:35 PM
	Examin		4a. Facility Name (If not institution, give	- 4		4b. City, Town, or t	4 .	1	4c. County of Deat	
			1	spital			offown	100.000	St. Mai	
	Funeral Director		5. Social Security Number 6. Sec. 10 10 10 10 10 10 10 10 10 10 10 10 10	7. Age (In yrs. last b		Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)
			Usual Residence of Decedent	/ 0				05/21/19	920   Mar	yland
	how		10a. State 10b. County	10c. City, To	wn or Loca	ation				10d. Inside City Limits
	Ba-f-	Director	Maryland St. Mary'	s Damero	n					1 ☐ Yes 2 No
	dith th	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	s 23s		18685 St. Jeromes		40.14	20628			nited Stat	
	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	13. W	as Decedent of His res, specify Cuban	panic Origin? (S , Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
920	urs at	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	☐Yes 2MNo	Specify:		Specify: Whi	te
21215-0036	72 hours atter death with the Maryland natural', or items 23a or 28a-f ehow deal Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade			nt's Usual Occupat		tking 1	6b. Kind of Business/	
2	within ene. then "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	O NOT use retired)	ing most of no.	_		
2	Hygien ther ther ther ther		12 17. Father's Name (First, Middle, Last)	Но	memal		18 Mother's Nes	One (First, Middle, M	wn Home	
Maryland	o da b	Be c	Jesse Redman						alderi Sumame)	
2	should nd Men marke umatic	2	19a. Informant's Name/Relationship (Ty	pe, Print) 19	b. Mailing		Lucy Be.		City or Town, State, Z	lip Code)
	nd 2:		Judy Bradburn-DeVa	ult/Daughter 4	3670	Deer Run	Court.	Leonardt	own MD 2	0650
altimore,	of Health Item 27 other tr		20a. Method of Disposition	20b. Place	of Disposit	tion (Name of story or other place			Oc. Location - City or	Town, State
Ē	Page nent ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ichae	1's Cem.	01/2	0/2007 R1	dge, Mary	land
Satt	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service License	30	22. 1	Name and Address	of Facility Br:	insfield	Funeral Ho	me, P.A.
<u>-</u>	₹0 = € d			ield, Jr. M0005	2   229	955 Holly	wood Roa	ad, Leona	rdtown, MD	20650
		11 1	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.	o not enter	the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	SEPSIS						
	Examiner			Due to (or as a consequence	e of):	A				12/1/5
		le.	Sequentially list conditions, it any, leading to immodiate cause. Enter Underlying	Data to for ser a property save	a of):			- 1		Λ
	cuted	Examin	Cause (Disease or injury that initiated events	UNINA	rry	TRACTI	NITEC	Tion		DAYI.
ó,	e exe		resulting in death) Last	Due to (or as a consequence	e of):					
8760,	cate be executed physiclen and the burial-transit	dicai		J	_					
9	eath certific attending p	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy						
Вох	death certifi e attending i od for use as	clan	in the past 12 months?	1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		ctopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
P.O.	0 0 0	Physician/Me	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	9☐ Unknown						
υ, σ	law requires that the es been signed by th 2 should be detache		Part II. Other significant conditions cor			lerlying cause giver	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	w require been sig should b	edt	- Manifile)	> MITHUTIS				1 ☐ Yes	3 □ Pro 3 □ Pro	obably 4 Unknown
Division of Vital Records,	e law requ hes been je 2 shoul	Completed by	· MRKINST	NI MENSE				24a. Was an autopsy	24b. Were au	topsy findings available
Œ	The ete h pege	Com						perform	ed? death?	2 No
/ita	Physician: Th this certiticate rel director, peg	Be	25. Was case referred to medical examiner?	I task				th (Check only one	)	
of o	G .5	P.	1 Yes 2 No	lospital: patient 2 EPVC 28a. Date of Injury 28b	Outpatient . Time of	3□ DOA Other	4 🗀 Nursing H		ice 6 Other (Spec	cify)
U <sub>O</sub>	ding h. After tuner	tion	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury Work? M 1 Y	es 2 No	28d. Describe how	vinjury occurred	
/isi	or Attending atter death. Director: Aftel in by the tune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm, stree			28f. Location (Stre	eet and Number or Ru	ral Route Number,
ā	s atte	Certification;	4  Homicide determined	building, etc. (Specify)				City or Town,	State)	
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely tilled in by the tuneral	edicai (	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death o and/or inve	occurred at the time stigation, in my opi	e, date and place nion, death occu	, and due to the car rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License			d. Date signed (Month	
			1 /4 free	N	13	DS	6096		1-17-0	7
	300		30. Name and address of person who co	mpleted cause of death (Item 23a	(Type, Pr	rint)	- 2 - :	120	1-17-0 Moral Ton	1.04
			RATENNER		STM	Mays Ho	877777	, LET	UDJUS IUN	M MD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	ha	all a				

a.m.

7, 2007

Box 68760 Records, P.O. Division or Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: filled in by

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2101 Medical Park Dr. # 200, Silver Spring, MD 20902 M.D. 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Firozvi

Kall Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) January 8, 2007

		For	State of N	/laryland / Dep	partment of I	Health and	Mental Hy	giene			
		1 - State Registrar		C	ertificate of	Death		Reg. No	01930		
Physic /Med		Decedent's Name (First, Middle, FRANCES	M.	BENSON			2. Date of De Month January	Day You	3. Time of Death 1:15 A M		
Exam		4a. Facility Name (If not institution, Brooke Grove Re				or Location of De Spring	ath	4c. County of De Montgo			
Funera Directo		5. Social Security Number 212–14–5769	5. Sex 1 □ M 2 ★ F	Age (In yrs. last birthda 90 Yrs.	y) If Under 1 Year Months Days	If Under 24 H Hours Mi		th y, Year) 3 1916 Was	rthplace (State or Foreign Country) Shington, D.C.		
Maryland I-f show fled at	tor	Usual Residence of Decedent   10a. State   10b. County   Md .	ia. State 10b. County 10c. City, Town or Location								
with the 3a or 28a t be noti	l Direc	10e. Street and Number 18131 Slade Sch	ool Road	l	10f. Zip Code	20860		10g. Citizen of What C	*		
1215-UU36 within 72 hours after death with the Maryland ene. than "natural" or Items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1   Yes 2 2 If Yes, Give Year or Dates	No No	I B. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		nerican Indian,		
Z15-UU36 Ithin 72 hours af te. an "natural", or Medical Exam	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/In									
filed Hygi	Φ	12 17. Father's Name ( <i>First, Middle, L</i> Robert McMill		Нот	memaker	18. Mother's N Hanna	ame (First, Middle, h Baine	,	ome		
Marylan nd 2 should be sith and Menta 27 Is marked r traumatic ev	-	19a. Informant's Name/Relationshi			iling Address <i>(Street</i>		Rural Route Number	er, City or Town, State, Maine (	Zip Code) 04105		
battimore, Marylan permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev		20a. Method of Disposition  1 ☐ Burial 2 🗷 Cremation  4 ☐ Donation 5 ☐ Other (Sp		<del>e</del>	position (Name of ematory or other pla litan Cre	1	Date ./9/07	20c. Location - City of			
permit. Departm Importar any Inju		21. Signature of Funeral Service L			22. Name and Addre Muriel	ess of Facility H. Barbe	r Funeral	·			
Physician /Medica Examine		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each	INANITION is a consequence of):	nter the mode of dyi	ng, such as card	iac or respiratory ar	rrest,	Approximate Interval Between Onset and Death		
ficate be executed ficate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	RADIATION s a consequence of):  OVARIAN Cas a consequence of):		<b>-</b>					
oo ou,	dical		d								
w requires that the death certifications are signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	☐Ectopic pregnanc	у		23d. Date of di Month	elivery Day Year		
requires that the een signed by the	Ď.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.  1   Yes   2   No   3							to the cause of death?		
The la	Completed						24a. Was autop perfor	osv nrior to	nutopsy findings available completion of cause of		
Or VItal Physician: 7 rithis certifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		ont 2000A Oth		eath Check onl of				
ald this	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpa 28a. Date of In		BIR SUDOA	4 Nursing		dence 6 Other (Sp	ecify)		
or Attending frer death, Director: After in by the funer	Certification:	1 🗹 Natural 5 ☐ Pending 2 ☐ Accident investigs 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place of in	njury - At home, farm, setc. (Specify)	M 1 □	rk?  Yes 2□No		Street and Number or F	Rural Route Number,		
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fur	Medical Cer	29a. Certifier 1 ★ Certifying (Check only 2 Medical E	Physician: To the bes xaminer: On the basis and manner:	of examination and/or	ath occurred at the ti investigation, in my	me, date and pla opinion, death of	ace, and due to the courred at the time,	cause(s) and manner a date and place, and du	as stated. se to the cause(s)		
To th To the compl	Me	29b. Signature and title of certifier	1/1/		29c. Licens	se number		29d. Date signed (Mor			
4		30. Name and address of person EVELYN D. JACKS			e, Print)	•	TE 200,	OLNEY, MD.	20832		
§ S	tate	31. Date filed (Month, Day, Year)	32 Regis	trar's Signature							

			For State Registrar	State of Maryland		tment of			ene g. No. 0 0	The same of the sa	019	31
	8-g		Decedent's Name (First, Middle, Last)					2. Date of Death Month		Year	3. Time of	Death
	Physicia /Medic		Beverly Young	Brooks				January			2:15	P M
	Examin		4a. Facility Name (If not institution, give	street and number)	4	b. City, Town	, or Location of Death	1	4c. County	of Death		
	8		Arden Courts				r Spring	10.0	Montgo	-		
	Funeral:		5. Social Security Number 6. Sex	M 250 F		Months Day	ar If Under 24 Hrs. 's Hours Min.	8. Date of Birth (Month, Day,		9. Birthpla Countr	ce (State o	or Foreign
***	Director		577-44-9217 Usual Residence of Decedent	73				Sept. 2	+,1933	wasnı	ngton	1, DC
	yland yland		10a. State 10b. County	10c. City,	Town or Loca	tion			· · · · · · · · · · · · · · · · · · ·	10	d. Inside C	ity Limits
:	a-1-s	ctor	DC N/A	Wasi	hingto	n					14 Yes	2 🗆 No
	है <b>दे</b> है <b>28</b>	Director	10e. Street and Number		0	10f. Zip Code	•	10	g. Citizen of W	hat Count	y?	
	23e		7032 Wyndale St.			2001			US			
_	er de Hem Hem	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	If Y	is Decedent of es, specify C	f Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- America k, White, e		
50	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	No 1954 If Yes, Give Year or Dates: 1994	1	Yes 2131	lo Specify:		Specify:	Blac	k	
รุ	filed within 72 hours after death with the Maryland Hygiene. In the Macical Examiner must be notified at ent, the Macical Examiner must be notified at	ted	15. Decedent's Edu	cation	16a. Deceder	nt's Usual Occ	cupation	. 1	6b. Kind of Bu			
<u> </u>	P. Br. "n	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	NOT use ret	ne during most of wor ired)	king				
N	ygien rer th	Completed		4	Nursi	ng Proi			Educa			
	be fill ita! Hy id oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, N	laiden Sumam	θ)		
<u> </u>	should and Men marke umatic	၉	Thomas M. Brooks		40- 14-18-	4.1.		ce Young	O: T		2 - 4 - 3	
<u>a</u> a	U (0 = m)		19a. Informant's Name/Relationship (Ty	27			et and Number or Ru		100			
	1 and 2 Health tem 27 other tra		Barbara B. Jackso 20a. Method of Disposition	20b. Pla	ce of Disposit	ion (Name of	St., N.W.		COn D			
	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		<sup>netery, crema</sup> aneake		tory 1/10	/2007 R	eltsvil	1 <sub>0</sub> M	TD.	
	그 된 본 분 .		21. Signature of Funeral Service Licens				dress of Facility		00 Geor	-		N.W.
ñ	Depe impo sny ir		I (inclos J.	housson	Mc	Guire :	Funeral Se			_		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	ne cause on each line.			ee s Di	0	st.		Approxima Interval Be Onset and I+25	tween Death
,09/80	cate be executed physicien and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	pare	NSION						
O. Box 6	The law requires that the death certific ste has been signed by the attending p page 2 should be deteched for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 2 Lekspans							23d. Date of delivery N 33- Month Day Year	
ds, P	uires that i signed b id be dete	d by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of			
		Completed						24a. Was ar autops perform 1 Yes 2	ed?	Vere autoporior to combeath?		available cause of
<u> </u>	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital.		-5-	0.1	ath (Check only one				
0	Phyt r this ral dii	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 2	R/Outpatient 28b. Time of	3LJ DOA	4 Nursing F	lome 5 Reside			)	
0	ding Th.	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		njury at <sup>/</sup> Vork? □ Yes 2 □ No	200. 2000.120 110	w inquity cocum			
DIVISI	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	СӨ	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	Hospital 24 hours 2 Funeral I riely filled	edical (	Check only onel	iner: On the basis of my knowl and manner stated.	ladge death on and/or inve	secured at the stigation, in m	time date and place ly opinion, death occu	, and due to the ce irred at the time, da	use(s) and ma ite and place, a	nner de ets and due to	itad. the cause(	(s)
	o the o the orthe	Med	29h Signature and tate of certifier	2 /		29c. Lice	ense number	25	d. Date signed	i (Month, E	Day, Year)	
. (	F 3 F 8		1 Voent &	hahon no	•	(	2543	1	123	1	1/0	7
	141	1	30. Name and address of person who c							/	, ,	•
			106 Irving St.,	N.W. Suite 20	00, W	ashing	ton, D.C.	20010				
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	le Soo	alls)	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Burris 01 08 orence 1020 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospice at the Lake Wicomico 11561 castal If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M **XX**F Months Days Hours **Director** 221-03-0810 90 7, 1916 Delaware Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7531 Titleist Drive 21801 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No White If Yes, Give Year or Dates: Specify þ Specify: 3 Widowed 4 □ Divorced "natural" untal Hygiene. ted other than "natura c event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental I Addison G. Burris ဥ other traumatic Sallie "Stuart" 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adele Davenport / Daughter 7531 Titleist Drive, Salisbury, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If ite any injury or of once. Had Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bridgeville Cemetery 01/12/2007 Bridgeville, DE 21. Signature of paral Society insee ParsellAdrumeral Homes & Crematorium 202 Laws St., Bridgeville, DE 23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Obstructive disease or condition resulting in death) hronic /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 2No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed?
1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of has death? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: after death.

I Director: A
d in by the fu within 24 hours after

To the Funeral Dire

completely filled in b

State

Registrar

Medical

3 Suicide

29a. Certifier

4 Homicide

HUBUS

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

WWOOD

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

D0058410

WIARIS

26266 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** William Lyles Carr, Jr. Idru /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-25-1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign . Social Security Number 216-16-8 **Funeral** Days Min 1 M M 2 □ F Months Hours 83 Baltimore, Md. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene. | other then "naturel", or items 23a or 28a-f show | other the Medical Examinar must be notified at Md Talbot Bozman 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22987 Twin Pines Rd. P.O.Box 214 21612 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onen of Heatth and Mental Hygiene.
net if item 27 is marked other than "naturel, or ites
nry or other traumatic event, the Macical Establians
nry or other traumatic event, the Macical Establians. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self employed Business Owner 12 years 4 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Lyles Carr Edith Skipwith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21612 19a. Informant's Name/Relationship (Type, Print) 22987 Twin Pines Rd.P.O.Box 214 Bozman, Md. I Health a item 27 I Betty Roberts Carr (wife) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages to Department of Himportant: if ite eny injury or ot once. Capitol Crematory 1-13-2007 Dover, De 1 ☐ Burial 2 🛣 remation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses R. Carroll Hurley Funeral Home, PC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a consequence o) Examiner 065Kutre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ig physician and as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by ig a 1 es 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 400 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 2 ER/Outpatient 3 DOA inis After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funerei Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

10+VA

State Registrar

29b. Signature and title of certifier

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Ampistrar's Signature

W, worte

2007

DHMH 17 Rev 1/2001

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219 S. Washingth St. Easter.

29d. Date signed (Month, Day, Year)

State Registrar

HARRY

COOHBS,

Maryland 21215-0036

altimore,

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

3460

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 1 0 2007

Suite 203A

WASHINGTON

WALDORF, MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend it em Maryand 70 8875 1 1 1 23 1 1 2 and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9 2007 ear **Physician** January 3:30 A M Gertrude COHEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Muriel House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year Peb. 24, Year) 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖵 F 84 Director Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 United States 11701 Stonington Place death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Owner Textiles 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Cohen Israel Emas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11701 Stonington Place, Silver Spring, MD 20902 19a. Informant's Name/Relationship (Type. Print) Marcie Emas, Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 🛛 Removal from State 4 Donation 5 Dother (Specify) 01/10/07 St. Albans, NY Montefiore Cemetery 21. Signature of Funan I Street License Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsease or right) that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Hospital: 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA ۴ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Living 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0

Registrar
DHMH 17 Rev 1/2001

State

1355 Piccard Drive #100, Rockville, MD

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32 Registrar's Signature

Gen Wroblewski, M.D.

31. Date filed (Month, Day, Year) JAN 1 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day January 15, 2007 12:24 **Physician** Р Joseph Demko, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's Bayside Care Center Lexington Park 8. Date of Birth (Month, Day, Yea July 11, 19 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **XX**M 2□ F Yrs Maryland 70 220-34-5306 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2\(\infty\)No Director St. Mary's St. Inigoes Maryland 1 4 1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 48593 Seaside View Road Lot 25 20684 Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes XX No laltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Veronica Dvorchak Joseph Demko, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any Injury or other trauonce. P.O. Box 725, St. Inigoes, Maryland 20684 Vivien Demko / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 17, 2007 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley Garliner Funeral Rome, P.A. P.O. Box 270, Leonardtown, Maryland 20650 nechael 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) ta11402 to **Physician** /Medical Due to (or as a consequence of): a denocalcirome colon **Examiner** metzstzhic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cancel colun ロイフィ e storate To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician a s the buriat-1 Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has e 2 s autopsy performed? Yes 2 page 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 Tes Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) D61719 January 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dhananjay Bhavsar, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

**JAN 16** 

egistrar's Signature

			For State Registrar		State	of Ma	rylan		epartment o Certificate d			lental Hy	•	ne <sub>Na</sub> 2 () (	17	01937
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			5. Social Security N			7 Age	(In vrs	last birth			If Under 24 Hrs.	8 Date of B		Montg		place (State or Forein)
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	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
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Ba	Deportr Importe any inju		23a. Part1 Enter the disease, or con	Hard	ine	) P.	.O. Box	k 270,	, Leona	ardto	wn, Mary	Land 206		Troie, T.A.
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Division	al or Attendi s after death. al Director: A ad in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	ijury - At hor tc. (Specify)	me, farm, stre					28f. Location (5 City or Tox	Street and Nu vn, State)	umber or Run	al Route Number,
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		-	30. Name and address of person who	completed cause of	death (Item :	23a) (Type, I	Print)					,		1
74			James P. Jarkoe, M.D				, Holl	ywood	, Mary	land	20636			
	Sta Registr		JAN 1 6 2007		rar's Signatu									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year January JAMES J. FRAMPTON, JR. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Easton Hospital Talbot he Memorial If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F 79 215-20-4547 Yrs. AUG 8, 1927 Director MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits rthan "natural", or iteme 23a or 28a-f ahow the Medical Examinar must be notified at TALBOT MD EASTON 1 ☐ Yes 2 😿 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10620 HINERS LANE 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣No þ Specify: 3X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 COMMERCIAL WATERMAN SEAFOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be find and Mental H JAMES J. FRAMPTON, SR. MARY AGNES PRICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any injury or other trau ELIZABETH DIANE CONNOLLY/DAUGHTER 11365 HOLLY ROAD, RIDGELY, MD 21660 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 1/5/2007 EASTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner alcohol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? ۵ ate has been sign page 2 should be 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? a Hospital or Attanding Pl 24 hours after death. a Funeral Director: After th 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours all To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 64043 TANuary tin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+IVA M.D. 219 S. WASHINGTON ST., EASTON, MD 21601 PAUL W. MONTE, 32. Repartar's Signature State 2007 Registrar

DHMH 17 Rev 1/200

Framston

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P.O. Box 68760.

Division of Vital Records.

			For State Registrar	State of M	aryland		artment of tificate of			tal Hygier	71111	7 01940
	Division		1. Decedent's Name (First, Middle, L	.ast)						Date of Death	Day Ye	3. Time of Death
	Physici /Medic	_	ELLIOTT F							NUARY 6,		9:10 P M
	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town,				4c. County of I	
ě,		ш	GLADYS SPELLMAN  5. Social Security Number 6.		ME. Age (In yrs. Ia:	st birthday)	If Under 1 Yea	CHEVER	24 Hrs.   8. [	Date of Birth	9	GEORGES  Birthplace (State or Foreign
	Funeral Director		098-12-6135	1 <b>⊠</b> M 2□F	87	Yrs.	Months Days	Hours	Min. (	Month, Day, Yes	ar)	Country) EW YORK
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	ehov	ă	10a. State 10b. County	COMPAN	Toc. City,	TOWITOTE						1 TYPes 2 No
	28a-f	rect	MARYLAND MONT  10e. Street and Number	GOMERY			SILVEI 10f. Zip Code	R SPRII	NG	10g.	Citizen of Wha	al Country?
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	hours after death with the Marylan tural; or itema 23a or 28a-f ehow al Exprinter rusal be rediffied at	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U.S.	. 13.	Was Decedent of f Yes, specify Cu	Hispanic Ori	igin? (Specify	Yes or No-	14. Race -	American Indian, White, etc.
g	or He	by Fu	1 Never Married 2 Married	11X Yes 2	] No WWII		1 ☐ Yes 2 <b>X</b> ☐ N			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify:	WHITE
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<u> </u>	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship ERROL FORGOSH-SO				ng Address (Stree MILEST(				-	
<u>ත</u>	f Heal tem	i ji	20a. Method of Disposition		COL	ice of Dispo	sition (Name of natory or other pi	1	Date			y or Town, Slate
Ê	Pages nent of int: If it		1 🔀 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec						01/09/2	2007 CLA	RKSBUR	G, MARYLAND
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ue <sup>-12</sup>			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each	ed the death. line.	Do not ent	er the mode of dy	ing, such as	cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
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õ	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or a	is a conseque	ence of):						
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Rox	death a atten	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal c	death 3[	Ectopic pregnan Other (specify)	су			Month	
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	sicier certif irecto	o Be	25. Was case referred to medical examiner?	Hospital:	****	'D'Outestan	. 20 DOA 0	Whon	e of Death (Ch		о Пон	(0
ō	y Physer this erat di	1-1	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date of In	ijury 2	28b. Time o	I 3LI DON	4V 140		5 Residence		(Ѕреспу)
<u>o</u>	ath. r: After e funer	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	(Month, E	Day Year)	Injury		ork? ∐Yes 2 ☐	No			
Division of	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	289. Place of I	njury - At hometc. (Specify)	ne, farm, str	eet, factory, office	9		Location (Street City or Town, St		or Rural Route Number,
	Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certificitiely filled in by the funeral director,		X									
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	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of contifier	A A	statou.		29: Lice	nse number		29d.	Date signed (A	Month, Day, Year)
	10(70		> × MI	any			016	2-73	MA		971	+
			30. Name and address of person wh				Print) DAD, CHE	VERLY,	MARYL	AND		
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Physic	ian	1. Decedent's Name (First, Middle, Li							Month	Day			
/Med	cal	Francis Vito  4a. Facility Name (If not institution, gi	Fabrizio			4h Cih	Town or Location	on of Dogth	Januai			9:30	а м
Exami	ner	Holy Cross Hosp		inber)		,	Month   January 6, 2007   9:3						
Funeral		Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)	II Under	1 Year If Und	der 24 Hrs.	8. Date of Bi	rth	~		or Foreign
Director		579-22-9986	X⊠M 2□F	81	Yrs.	Months	Days Hour	rs Min.	June 2	L, 19	25 Was	shingtor	ı, DC
and *		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside (	City Limits
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28e-	Director	Maryland Montgo	цегу		Silver					10g. Citi	zen of What	Country?	
h with	O E	15101 Interlact	nen Driv	re, Apt.	207		209	906			USF	A	
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or of the		t Burial 2 ☐ Cremation 3 (		C1-1-	cemetery, crer	natory`or o	ther place)	; J	an. 11,				
permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than any rigury or other traumatic event, tha Magnetic apprecia		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice						<u>;                                      </u>					ryland
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bhysician end Examiner and Italian end Ita	cai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acut  Due to  b. Due to  c.	e Myoca (or as a consec (or as a consec (or as a consec	quence of):	Infar	ction					Onset and	Death
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To the Hospital or Attending within 24 hours after death. To the Funerei Director: After completely filled in by the funerei	Medical C	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	miner: On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or in	occurred vestigation	at the time, date in my opinion, o	and place, death occur	and due to the red at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(	(s)
To th withir To th comp	ž	29b. Signature and title of certifier		1 . n		290		er		29d. Date	a signed (Mo	nth, Day, Year)	
nul		> Throw	No /	sulfe	ery		D56691			Janua	ary 8,	2007	
177		30. Name and address of person who				,							
		Ghousia Sultana,				len R	oad, Si	lver	Spring,	MD :	20910		
St Regist	ate rar	31. Date liled (Month, Day, Year)  JAN 10 2	2007	iðgistrar's Signa	K A	act s							

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F rtificate of			gienė) [] [] Reg. No.	01943
	Physici		Decedent's Name (First, Middle, La.     Mildred Portis	,				2. Date of Dea Month Januar	Day Yea	3. Time of Death 2:45 PM
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	Januar	4c. County of De	
	LAdiiii		Aberdeen House			Rockvi1			Montgo	
A	Funeral		Social Security Number 6. S		(In yrs. last birthday)			8. Date of Birtl (Month, Day		Birthplace (State or Foreign Country)
	Director		400 42 7000	□ M 2□x 9	6 Yrs.	Nontrio Bayo	110010	Aug. 10	, 1910	Texas
and	M 11		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Mary	t sho	to	Maryland Prince (	Genroes	Laurel					1 X Yes 2 ☐ No
the	r 28e	Director	10e. Street and Number	occiges	Daurer	10f. Zip Code			10g. Citizen of What	Country?
death with the Maryland	23a o	ai D	13139 Winding T	rail Road		20707			United St	ates
	S E	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - Ar Black, W	merican Indian,
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d ig	han.	mpį	Elementary/Secondary (0-12)	College (1-4or 5	+)		during most of work	9		
N B	al Hygiene. I other than '		17. Father's Name (First, Middle, Last)	5+	Tea	cher	18. Mother's Name	/First Mindella	Education	n
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			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused	the death. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arr	est,	Approximate Interval Between
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ta v	as be	Completed	Parkinsons Disea	ise				24a. Was a autops		autopsy findings available completion of cause of
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	ertific ector,	Be	25. Was case referred to medical examiner?				26. Place of Death			
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Attending P	ath. or: After ne funer	ation	27. Manner of Death  1   Natural 5   Pending  2   Accident investigation		Year) 28b. Time of Injury	Work	/ at k? Yes 2 □ No	28d. Describe h	ow injury occurred	
al or Att	s efter de N Directo ed in by ti	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
DIVISION OF VITAL MECOLOGY, F.O. DOX 00/00, to the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical (	29a. Certifier (Check only one) 1 ☑ Certifying Ph 2 ☐ Medicel Exam	ysicien: To the best o niner: On the basis of and manner stat	examination and/or inv	occurred at the time vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the co	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
΄.	To the comp	W	29b. Signature and title of certifier  Will Rmv.	m J.	Ninala	29c. License D452			9d. Date signed <i>(M</i> o January 9,	
{			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)				· · · · · · · · · · · · · · · · · · ·
			Wilkerson Ninala	, M.D. 34	4 Universi	ty Blvd.	W Suite	113, Si	Lver Sprin	g, MD 20901
	Sta		31. Date filed (Month, Day, Year)	32 Megistra	r's Signature					
DHMH	Registr		0.114 1 0 20	Carles .	s to fo	artis)				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 1. Decedent's Name (First, Middle, Last) JOHN GAUDET 2. Date of Death 3. Time of Death Month Day Physician 2017 01 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ltimor Medical ( timore enter If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, Year) Jan. 31, 1952 **Funeral** 9. Birthplace (State or Foreign 11**⊘**M 2□F West Virginia 234-84-7033 Months Days Hours Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location item 27 le marked other then "natural", or iteme 23a or 28a-f ehow other treumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Maryland Prince George's Beltsville 1 Tyes 24 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2501 Garrett Avenue 20705 United States Funeral 12. Was Decedent Ever in U.S. Agned Forces? 1∕⊆ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married John Gander Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Guide/Outfitter Hunting/Fishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental h Pages 1 and 2 should be Stanley Joseph Gaudet Mabel Sue Cutright 19a. Informant's Name/Relationship (Type, Print)
James S. Gaudet -brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 Brookwood Drive Evington, Virginia 24550 if item 27 le 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/8/2007 Alexandria, Virginia permit. 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee 4400 Powder Mill Road Beltsville, Maryland 20705 homas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** DeDSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examine Vital Records, P.O. Box 68760, P.O. R. Eleo (2) Grand of the law requires that the death certificate be executed sete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has 1 ☐ Yes Division of Vital Br 32 (Wite out ) Ok Lav Pr To the hospitals Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifice After this certifice funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KAST MI) R15180

State Registrar

MIRAN 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Balhmon 32. Registrar's Signature

AN 102007 enter 5th floor SICI

		1	For State	State of	Maryland		artmen rtificate			d Men		ene	-7	01015
			Registrar  1. Decedent's Name (First, Middle, Las	it)							Date of Death			Time of Death
	Physicia	an	SEVERO	R.	GARCIA	A				Jo	Month NUURY	7 200	7 /	D:06 PM
S.	/Medic Examin	-	la. Facility Name (If not institution, give				4b. City,	Town, or	Location of De		1	4c. County of De	ath	•
			DOCTORS COMMUN	VITY HOS	PITAL			LANH				PRINCE		
	Funeral		5. Social Security Number 6. S		7. Age (In yrs. las		If Under Months		If Under 24 H Hours N	Airo /	Date of Birth Month, Day,	Year)	Country)	(State or Foreign
	Director		0/9-24-96//	₩ 2□F	74	Yrs.				J.	AN. 25	, 1932 PU	ERTO	R1CO
	w w	_ ⊢	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. I	nside City Limits
	Aaryk f sho ed at	ō	MD DDINGE	CEODOEC		т /	NHAM						1	XTYes 2 □ No
	the the 28a-	Director	MD. PRINCE  10e. Street and Number	GEORGES_		Li <i>E</i>	10f. Zip	Code			10	Og. Citizen of What	Country?	
	3a or		7804 FISKE AV	E.				2	20706			U.S.	Α.	
- \	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther, the Medical Examiner must be notified at	Funeral	11. Marital Status		dent Ever in U.S.	. 13.	Was Deced	dent of Hi	spanic Origin? n, Mexican, P	? (Specity	Yes or No-	14. Race - Ar Black, W		ndian,
, o	after or ite	Fu /	1 ☐ Never Married 2√ Married	1 √ Yes If Yes, Give	<sup>2□ No</sup> 1950-	l l	1X Yes		Specify:			Specify:		
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d 2	be filed within 72 ho ital Hygiene. Id other than "natul event, the Medical	Be C	17. Father's Name (First, Middle, Last,							Name (Fi	rst, Middle, N	Maiden Surname)		
an an		To B	JESSE	G	ARCIA				C	CLARA		JACKSON		
Maryland 21	S D E E		19a. Informant's Name/Relationship (			19b. Maili	ng Address	Street a	and Number o	r Rural Ro	oute Number,	City or Town, State	, Zip Cod	le)
Σ	5 = 2 I		LACOTHIA GARCI	A/WIFE					/E., LA					
30 ore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from S	Cei	ace of Dispo metery, cre	osition (Nar matory or o	me of other plac	e)	Date	1	20c. Location - City	or Town,	State
₹ Ē	Pages ment of I ant; If its ury or o		4 Donation 5 ☐ Other (Special	(y)	ARL				CEM, 1	<del>-22-2</del>	2007	ARLINGTO	N, V	Α
Severo Baltimore,	pernit. Pag Department Important; I any injury o		21. Signature of Funeral Service Lice	human	мооо	C	HAMBE	ERS F	s of Facility UNERAL LAND A	HOMI VE.,	E & CRI	EMATORIUM DALE, MD.	,P.A 207	37
$\mathcal{D}$	SECTION 1		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	aused the death.								App	proximate erval Between
	Physician		Immediate Cause (Final disease or condition		SPIRAT	DRY	F.	ALLU	RE				On	set and Death
	/Medical	Ш	resulting in death)		or as a conseque			1					-	V V V V V
	Examiner		Sequentially list conditions.		ASTATL		CARO	LNDO	AA L	UNG			_~	north
	p ii	iner	Sequentially list conditions, if any, leading to limitediate cause. Enter Underlying Cause (Disease or injury		or as a conseque									- 1.
	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Pol	or as a conseque	c BIA ence of):		SEP	212				-~	2 WKS
8760,	be e) lician buria			,										
387	icate phys s the	dical		d										
9 X	death certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come pf pregnan							23d. Date of	delivery	
m	death e atter	icial	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregn	oirth 2 🗆 Fetal nant at time of de		□Ectopic p □ Other (s					Month	Day	/ Year
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ς. Π	Attending Physician: The law requires that the death certific roteath. ector: After this certificate has been signed by the attending pl by the funeral director, page 2 should be detached for use as it	by P	Part II. Other significant conditions	contributing to de	eath but not resul	ting in the u	underlying	cause give	en in Part I.			bacco use contribut		
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>	hysic his ce il dire	으	1 Yes 2 No	7		R/Outpatie			4 L. INUISI			ence 6 Other (S	pecify)	
ū	ing P		27. Manner of Death 1 Natural 5 Pending		th, Day Year)	28b. Time Injury	M M	28c. Injur Wor	yat k? Yes 2 ⊟No		. Describe no	ow injury occurred		
sio	ttend leath. ttor: /	cati	2 Accident investigation 3 Suicide 6 Could not be		of injury - At hor	me. farm. s					Location /St	treet and Number o	Rural Ro	oute Number.
Division or Vital Records, P.O. Box	al or A s after or al Direct	Certification:	4 ☐ Homicide determined		of injury - At hor ing, etc. (Specify						City or Towi	n, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2	Medical (	29a. Certifier (Check only one)	miner: On the b	e best of my know easis of examinati ner stated.	vledge, dea ion and/or i	th occurred nvestigatio	d at the til on, in my o	me, date and popinion, death	place, and occurred	due to the c at the time, o	ause(s) and manne date and place, and	r as state due to the	d. e cause(s)
	To the	Me	29b. Signature and title of certifier				29	9c. Licens				29d. Date signed (M		, Year)
	3+1		MSNE	yer	M	D		D.	-1787	14	-	1-8-0	7	
	0 ( '		30. Name and address of person who	completed caus	se of death (Item	23a) (Type	Print)	ETTA	at c	174	, M.	D 2072	2	
	, St	ate	31. Date filed (Month, Day, Year)	32.	egistrar's Signat		Par Me	8						

			Stete Registrar	tate of Maryland			f Health and	Mental Hyg	eg. No.	01946
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)  A UL C  4a. Facility Name (If not institution, give stree	HAAS		4h City Toylo	and analise of Dan	2. Date of Dear Month	Day Yea 2 2	10:00 AM
	Exami	ner	8199 Edgewood Church	Road			n, or Location of Dea .erick	th	4c. County of De	
	Funeral Director		5. Social Security Number 6. Sex 577-20-5650	7. Age (In yrs. las 2□F 84	t birthday) Yrs.	If Under 1 Ye Months Da			, 1922 Pe	irthplace (State or Foreign Country) nnsylvania
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Modical Examinar must be mutified a	Director	10a. State 10b. County  Maryland Frederick  10e. Street and Number	10c. City,	Town or Lo		9	11	0g. Citizen of What (	10d. Inside City Limits 1 ☐ Yes 2⊠ No
	ath wit	ralD	8199 Edgewood Church	Rd.		21	702		United St	•
036	ours after de al', or items Examinar n	by Funeral	1 ☐ Never Married 2 ☒ Married 1	Vas Decedent Ever in U.S. .med Forces? XXYes 2 □ No Yes, Give ear or Dates: WWII	1	Was Decedent of fYes, specify C I ☐ Yes 2XXI	of Hispanic Origin? ( uban, Mexican, Pue lo <i>Specify</i> :	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify: W	
1215-0	within 72 ho ne. han "natur ne Mcdical.	Completed		n npleted) ollege (1-4or 5+)	(Give life. L		cupation ne during most of wo ired)	orking	16b. Kind of Busines	s/Industry
Maryland 21215-0036	be filed ital Hygi d other event, I	To Be Co	12 17. Father's Name (First, Middle, Last) Theodore Haas		For	eman		me (First, Middle, Market) a Dice		Preservation
ď	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Type, F Mildred A. Haas / Wi 20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	f e 20b. Plac	8199 e of Dispos <sup>etery</sup> Res norial	Edgewoo sition (Name of SEMAVER P Garder	d Church Jan.	Rd., Fred 10, 2007	City or Town, State, erick, MD Coc. Location - City of Frederick, Skkot Coc.	21702 r Town, State Maryland
- Table 1	Physician /Medical Examiner	er		ns that caused the death. It use on each line.  Outriple  Due to (or as a consequent)	Do not ente	ui Cato	ying, such as cardia	Hwy. Fre	derick, M	Approximate Interval Between Onset and Death
	leath certificate be executed attending physician and for use as the buriat-transit	Ical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  IF FEMALE: 23b. Was decedent pregnant  23c. If	Due to (or as a consequen  yes, outcome of pregnancy  Live birth 2 ☐ Fetal de	ce of):	Ectopic pregnan			23d. Date of de	livery
Э	at the dea d by the at etached fo	Physician/Med	1   Yes 2   No 9   Unknown 9	Pregnant at time of death Unknown	5 🗆	Other (specify)			Month	Day Year
cords,	law requires that the death es been signed by the atter 2 should be detached for t	Completed by	Part II. Other significent conditions contribut  Carcanara of Tr	IE PROPTATI		derlying cause g	oven in Part I.			o the cause of death?
י י	ste h	e Comple	HAPETES MELL  174 PERTENSION  25. Was case referred to medical	1705				24a. Was an autopsy perform	ed? death? XNo 1 ☐ Yes	utopsy findings available completion of cause of
5 2	his cer il direct	ToB	examiner? 1 Yes 2 No Hospita	il: 1 ☐ Inpatient 2 ☐ ER/	Outpatient	3□ DOA O	th a	th Check only one ome 5 Residen	ce 6 ⊡Other (Spe	cify)
	or in an object of attending repsicent: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification;	1 Shatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	D. Time of Injury	M 1 (	uryat ork? ⊒Yes 2⊡No	28d. Describe how	injury occurred	
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1	within 24 hours and to the Funerail completely filled	Medical	one) ar	- marmor stateg.	and/or inve	stigation, in my	opinion, death occur se number	rred at the time, date	se(s) and manner as e and place, and due d. Date signed (Mont	to the cause(s)
- A	PA		30. Name and addres 1 person who complete  GENGE - Shr TII he  31. Date filed (Month Day Year)	A. A.D. ed cause of death (Item 23a	a) (Type, P	D rint)	10587 140000			
<i>J</i> .	Stat Registra	e	GENGE 1- SKITH Le 31. Date filed (Month, Day, Year)	32 Segistrar's Signature	are	ECTOL 5	16 TRAIL	AUE; F	REDERICA,	LD. 21701

DHMH 17 Rev 1/2001

Box 68760.

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State
Registrar cchd per fh Amended #4 AJS Certificate of Death Reg. No. 1-9-07 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** PM January 8, 2007 4:05 Margaret Jane Jarrell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Ruxton Health of Denton Denton If Under 1 Year | ff Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 214-36-6193 **Funeral** 1 M 2 F Months Director August 8, 1938 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b Counts 10a State 27 ie marked other than "natural", or Items 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Caroline Denton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21629 United States of America 9189 Double Hills Road Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Caucasian þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 ie marked other than "n Efementary/Secondary (0-12) College (1-4or 5+) homemaker home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Louise Hess 2 Charles Raymond Althoft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Husband Department of Health a important: if item 27 is any injury or other trains 9189 Double Hills Road, Denton, Maryland 21629 Charles O. Jarrell, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place). 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) St. Peter's Catholic 1/13/2007 Queenstown, Maryland 22. Name and Address of Facility.
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 21. Signature of Funeral Service Licenses and pul, / noone 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf HYPOYIA Hours Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): EFFUSION Examiner LEMEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CELL LUNG CANCER be executed burial-transi BUAMOU Due to (or as a consequence of): 68760. nding physician Physician/Medical use as the Box ( IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the atter in the past 12 months?
1 Yes 2 No ō 4 Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? ate has been signed I page 2 should be det Part ft. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ ACKRY 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 2 After this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturaf after death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year) JAN 9 2007

(Check only one)

29b. Signature an

KeinBOW, MID 321 B 00M/N6)ALE 32. Registrar's Signature

ATTENDING

of death (ftem 23a) (Type, Print)

and manner stated

who completed cause

29c. License number

D00530

29d. Date signed (Month, Day, Year)

NUE HEDERA

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 18, 2007 **Physician** 4:10 pm м Johnson Jr Ernest Paul /Medical 4c. County of Death Frederick 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Golden LivingCenter-Frederick Frederick 8. Date of Birth (Month, Day, Year Nov 17, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1MM 2□ F 1925 Yrs. 220-26-6291 81 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show Maryland Frederick Frederick 1 Yes 2 □ No Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with "natural", or items 23a or adical Examiner must be 30 North Place 21701 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 18 Yes 2 No 1945-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 end 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: If Yes, Give Year or Dates: Completed by 3 XXVidowed 4 ☐ Divorced 1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Me alth and Mental Hygiene. 27 Is marked other than er treumatic event, the Me Elementary/Secondary (0-12) Coltege (1-4or 5+) Painter Commercial 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sr Carrie Ernest Johnson Nichols Paul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 39 Lavista Drive, Winter Springs, Florida 32708 Joan D. Boone, Daughter Item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Depertment of H Importent: If Ite eny Injury or ot ong Injury or ot 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Smithsburg Crematory Jan 21, 2007 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Funeral Service Liven <sup>22</sup>Keeney & Bastord P.A. Funeral Home 106 East Church St, Frederick, Maryland H00706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, ettending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ⋈ No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) signed by the e Division of Vital Records, P.O. 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 2 □ No 3 Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes al director, page 2 : autopsy performe 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Viursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manny of Death 1 Vatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 500 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and fittle of ce cause of death (Item 23a) (Type, Print) 30. Name and ad 31. Date filed (Month, Day, Year) State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year 5:00 Stanley John 4. 2007 Kowal January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Laurel Regional Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 M 2 □ F May 3, 1930 Michigan 378-26-7449 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☐ No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3128 Gracefield Road, #613 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No 1 Yes, Give Year or Dates: 1953-55 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) JHU/APL Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angeline Mary Zoladz Stanley J. Kowal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3128 Gracefield Rd., #613, Silver Spring, MD 20904 Rose Ann Kowal/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) 2007 Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd, W., Silver 21. Signature of Funeral Service Licenses Inc. Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical **Examiner** 

**Physician** 

Examiner

**Funeral** 

Director

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at</u>

Health tem 27 i

Pages nent of

72 hours after

3altimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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burial-trar attending physician for use as the burial ed by the a detached f signed by 1 page 2 has

certificate be executed funeral director,

Examiner Physician/Medical Completed by Be Certification: To

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical

State

Registrar

Immediate Cause (Final disease or condition resulting in death)  a.Septic Shock tue to (or as a consequence of):											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury that initiated events resulting in death) Last	b.Pncumenia Due to (or as a consequence of):  c.  Due to (or as a consequence of):										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year							
Part II. Other significant conditions Heart Failure	contributing to death but not resulting in the u	nderlying cause given in Part I.	1 ☐ Yes  24a. Was an autopsy performed?								
25. Was case referred to medical		OC Diago of Dag	1 Yes 2 2	No I Tes 2 No							
examiner?  1 Yes 2 No	Hospital: 1  Inpatient 2 ER/Outpatien	Othor	th (Check only one) ome 5  Residence	6 ☐Other (Specify)							
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	1	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	jury occurred							
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)							
	Physician: To the best of my knowledge, deat aminer: On the basis of examination and/or in and manner stated.										
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y											

D23649

3110 Gracefijeld Road, Silver Spring, MD 20904

January 6, 2007

DHMH 17 Rev 1/2001

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

M\d

2007

John Stuckey,

31. Date filed (Month, Day, Year)

		•	For State	State	of Mary	-	artment of I	Health and M		giene2 () (	07 01951
			Registrar  1. Decedent's Name (First, Midd)	le. Last)	-			D Gatt.	2. Date of De		3. Time of Death
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	/Medic	_	Marie 4a. Facility Name (If not institutio	n, give street and r	number)	Long	4b. City. Town.	or Location of Death		4c. County o	
	Examin	er									
	Europe		Atlantic Gene  5. Social Security Number	6. Sex		yrs. last birthday,	Berli If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	ester  9. Birthplace (State or Foreign
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_			Usual Residence of Decedent							1933	New Jersey
2	Mo H		10a. State 10b. County	•	10	c. City, Town or L	ocation				10d. Inside City Limits
N.		to	MD Some	rset		Princess	Anne				1 ☐ Yes 2 📉 No
di di	828	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	hat Country?
3	238	aic	33543 West Pos	st Office	Road		218	53		USA	
5-0036	items 23s or 28s-f show	Funerai	11. Marital Status	12. Was De	ecedent Ever Forces?	in U.S. 13.	Was Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race Black	- American Indian, , White, etc.
9	or is		1 Never Married 2 Mai	ried 1 ☐ Ye.	s 2 No		1 ☐ Yes 2 No		,	Specify:	
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121	then	mp	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT use retire	ю)			
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aryla	marked o	၉	John Wesley Ho			405 14:37		Eva Mar			New Zie Code)
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d) a	f Health item 27 other tra	1	John Abbott/Sc 20a. Method of Disposition	n	12	1514	Holly Sy	wamp Road.	Pocomo Date	oke City.	MD 21851 Dity or Town, State
altimore,	Department of H Importent: if its eny injury or ot		1 Burial 2 Cremation	3 □Removal fro	m State		osition (Name of matory or other pla	1			
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Balt	epar npor ny in	1	1. Signature of Funeral Je vice	Licensee		H	2. Name and Addr inman Fur	ess of Facility neral Home	2		
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0	ien a	Ä	resulting in death) Last	Due	to (or as a co	insequence of):					
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Вох	t use	an/	23b. Was decedent pregnant		outcome of p e birth 2		☐Ectopic pregnanc	ey .		23d. Date Mont	of delivery th Day Year
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P.O.	by the	Physician/Med	9 Unknown								
5,	igned be det	b	Part II. Other significant condit	ions contributing to	death but no	ot resulting in the i	ınderlying cause gı	ven in Part I.			bute to the cause of death?
brd	been si should					· · · · · · · · · · · · · · · · · · ·			1120	Yes 2⊡No 3	3 ☐ Probably 4 ☐ Unknown
20	as be	Completed							24a. Was		fere autopsy findings available for to completion of cause of
Æ å	ete hes page 2	E								ormed? de	eath?
		0	25. Was case referred to medica	al				26. Place of Deal			
	is cert	6	examiner? 1 ☐ Yes No	Hospital: 1	npatient	2 ER/Outpatie	nt 3 DOA Ot	her: 4 🗌 Nursing Ho	ome 5 ☐ Resi	dence 6 ☐Other	r (Specify)
	After thi	ë	27. Manner of Death	/8.4	te of Injury onth, Day Ye	28b. Time o	of 28c. Inju	iry at	28d. Describe	how injury occurre	d
Vision		atio	1 Natural 5 Pendi	igation	, <u></u> ,	,,		Yes 2 No			
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100	within 2 To the comple	ž	29b. Signature and title of certifi	er			29c. Licen	se number		29d. Date signed	(Month, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 BARBARA **Physician** JANE LEIBOLT 5:00 рм JAN. 16, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1214 Washington Street Unit 14 St. Talbot Michaels 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 🛣 F 82 Yrs. New York Director 064-20-5112 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or Iteme 23e or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Talbot St. Michaels Directo 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. and If item 27 ie marked other than "natural, or iteme 23e or item for other thaumatic avent, the Medical Examination in ury or other traumatic avent, the Medical Examination in man be 1214 Washington Street, Unit 14 21625 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Btack, White, etc. 1 ☐ Yes 2 ☑ No II Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2√ No Specify: Specify: White þ 3 ☐ Widowed 4 🗓 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fashion Merchandising Sales 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Victoria Tunnel Ernest C. Schuster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 1157 Cordova Road, Cordova, MD 21625 Jan Falcey/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. Hanover, Maryland 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Regisr. 1/17/07 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARTERIOSCIEROTIC CARDIDVASCULAR Immediate Cause (Finat disease or condition resulting in death) DISEASE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident Diractor: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after or To the Funaral Dirac completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) ‡ 29c. License number 29b. Signature and title, of certifier 29d. Date signed (Month, Day, Year) D 0057908 1117/07 atterson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 S. TALBOT ST, ST MICHAELS, MI) PATTERSON KOBERT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 200 14 37 48

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene AMEND#16aperFH1/18/07,BMW,MbCb Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 4, 2007 **Physician** 4:00 A.M. Lee M. Limbert, Jr. /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Montgomery Chevy Chase 4605 Norwood Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☑ M 2 □ F Yrs. May 5, New York, N. Y. 1943 Director 134-34-9008 63 Usuel Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Ifem 27 ie marked other than "naturel", or items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County 1 X Yes 2 ☐ No Chevy Chase **Funeral Director** Maryland Montgomery 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code U. S. A. 20815 4605 Norwood Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status Black, White, etc. 1 Never Married 2 Married 1做Yes 2□No Navy NYes,Give Yeer or Dates: Vietnam White Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Recruiter xecutive Quest Systems 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Ellen Newlands Lee M. Limbert 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 20815 4605 Norwood Drive, Chevy Chase, Maryland Barbara K. Limbert - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ŏ 1 ☐ Burial 2 【XCremation 3 【XRemoval from State = 5 1/9/2007 Falls Church, Virginia National Crematory important: any injury o 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service Licensee 20852 Donald. Approximate Interval Between Onset and Death th. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical 3-4 Hours Acute Myocardial Infarct **Examiner** Due to (or as e consequence of): Physician/Medical Examiner Hypertension Attending Physician: The law requires that tha daath certificate be axecuted inding physician and use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Elevated Cholesterol Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of): Obesity 23b. Did tobacco use contribute to the cause of death? ate has been signed by the page 2 should be detached Part Ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? t Ves XLING 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: edicai Certification: To 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Menner of Death 1 X Naturel 5 Pending investigation • 24 hours aftar death. • Funeral Director: Aft letely filled in by the fun 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò Residence 1 Certifying Phyalcien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 75] January 5, 2007 our D10298 ID 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) R. H. Sandstrom, M. D. 7701 Carroll Avenue, Takoma Park, Maryland 31. Date filed (Month, Day, Year) 32. Registrer's Signature State ENGLES ..

Registrar

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State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#23aI+2perMD1/10/07, BMW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 ear January 4, **Physician** 5:50 P Henrietta F. Shantz Levine /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 226-16-4033 1 □ M 2 📆 F 84 Yrs. Director Nov. 24, 1922 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryla Deperment of Heelth and Mental Hygiene. Important: if item 27 is marked other then "neturel", or iteme 23s or 28s-1 show any Injury or other treumatic event, the Madical Examiner must be notified at once. 1 Yes 2 No Director Chevy Chase Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20815 United States 8100 Connecticut Ave., #305 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 No 1 Never Married 2 Married Kimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Federal Government 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adrian B. Fink Esther Weinstein 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4412 Nuttall Road, Fairfax, VA Bonnie Miller, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Cemetery 01/10/07 Arlington, VA 21. Signature of Funeral Se vice License 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Onset and De Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 Months Failure to Thrive Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ettending physiclen and for use as the burial-transit Bilateral Pleural Effusions resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Progressive Renal Failure Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Bilateral Pleural Effusions 24a. Was an autopsy performed? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai completely (Check only and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 36272 JANUARY 04,2007 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven T. Kariya, M.D., 11501 Georgia Ave., Suite 515, Wheaton, MD 32. Angistrar's Signature 31. Date filed (Month, Day, Year) State JAN 10 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** January 2007 Bernice Martin 3:40p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreigr Country) **Funeral** Days Min. Months Hours 1 □ M 2 🕅 F Director 78 Virginia 226-30-1135 08/12/1928 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo St. Mary's Maryland Ridge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 48862 Seaside View Road 20680 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 X Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Housekeeper Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sam Buddy Martin Rose Harriston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Horace McClane/Son 45875 Broun Terrace, Great Mills, MD 20634 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Important: If any Injury o once, Peter Claver Cem. 01/19/2007 St. Inigoes, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee a Edward N. Brinsfield, 22955 Hollywood Road, Leonardtown, MD Jr. M00052 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsenand Death of dying, such as caldiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death been signed by the should be detached 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ∰Unknown 2∏ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has e 2 autopsy performed? certificate has irector, page 2 2□ No 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 21 No 1 Inpatient ို 1 ☐ Yes this 28b. Time of 28a Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: (Month, Day Year) Injury 5 Pending investigation 1 🗺 Natural 1 Tyes 2 No neral Director: v filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a:

To the Funeral C
completely filled i 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

(Check only one)

30. Name and address

James P.

31. Date filed (Month, Day, Year)

29b. Signature and title of

DHMH 17 Rev 1/2001

Jarboe,

2007

of person who completed

M.D

and madner stated

cause of death (Item 23a) (Type, Print)

29c. License number

24035 Three Notch Road, Hollywood, Maryland

29d. Date signed (Month, Day, Year)

20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:45 A Norma Jeanette Miller January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 23990 Rustic Way St. Mary's Hollywood If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🕅 F Yrs. Director 213-22-2113 80 01/24/1926 Washington, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sh notifled 1 ☐ Yes 2 No Directo Maryland | St. Mary's Hollywood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number o e 23990 Rustic Way "natural", or Items 23a dical Examiner must t 20636 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Heatth and Mental Hygiene. Interest if item 27 is marked other than "natural", or lite into 70 other traumatic event, the Medical Examine iny or other traumatic event, the Medical Examine. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Alfred Wise Dye Bessie Abell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23990 Rustic Way, Hollywood, Maryland 20636 Carol Lynn Cogar/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I-Important: If ite any injury or ot once, 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Ce 02/08/2007 Arlington, Virginia 21. Signature of Funeral Septice License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final congestive **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner 5 Chemiz Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical as attending p IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPI 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

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Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: Certification: within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) attendin 0055682 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23140 Moakley Wilkinson MD homas 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 7 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relation		<b>c</b> -	19b. Ma	iling Address	s (Street	and Numb	er or Run	al Route Numbe L03 Greent	r, City or Towi	n, State, Zip	Code)
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. Box 68	ith cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, of 1 ☐ Live	utcome pf pre		3□Ectopic p	regnancy	,			1	ate of delive	ery Day Year
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	4		30. Name and address of person Ravi Passi, M					#20	08, Ro	ockvi	ille, MD	20850		
	Sta	ite	31. Date filed (Month, Day, Yea	) 329	Registrar's S	Signature	A 50				,			
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DHMH 17 Rev 1/2001

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		Maryland a-f show ified at	ctor	10a. State 10b. County		10c. City, Tov	wn or Location Baltimo:	re					10d. Inside	City Limits
		with the	Dire		Im Bood		10f. Zip		216		10g. Citizen of		ntry?	
.ш.	36	rs after death I", or items 23 Kaminer mus		11. Marital Status un 1 ☐ Never Married 2 ☐ Married	k 12. Was Decedent B Armed Forces? 1 □ Yes 2 ☑ N If Yes. Give		13. Was Dece	dent of H cify Cuba	216 ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)		ce - Americack, White,	etc.	
. u	215-00	thin 72 hou e. an "natura Medical Ey	pleted k	15. Decedent's (Specify only highest g	Education trade completed)		a. Decedent's Usu (Give kind of wo life. DO NOT u	al Occup rk done o se retired	ation during most of work f)	ing	16b. Kind of E			
4	2	be filed tal Hygi d other event, t	Be	unk	unk			emp: ink	loyed 18. Mother's Name	e (First, Middle,		shir	ier	unk
	≥	nd 2 sho alth and 27 is m	-	Sean Monroe/sor		2	976 Harr	ogat	and Number or Rur e Way Abi	ingdon,			Code)	
ARY 19	ltimore	nit. Pages 1 artment of H ortant: If Ite Injury or ot		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 📉 Other (Spec	in state	20b. Place of cemete	of Disposition (Nar ery, crematory or o	ther plac	e)	Date	20c. Location	·	,	
IANU	Ba	Depi Impo		somme!	1 del		Baltim	ore.	ss of Facility Omy Board MD 2120	1		ore S	Street	
	A. The	/Medical Examiner  physician and the prujal-transit	ical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any learning to minerate cause. Enter Underlying Cause (Disease or injury that initiated events	a. CHRONIC  Due to (or as a  b. Due to (or as a  c.	C OBSTR	OCTIVE P				1651,		Approxima Interval Be Onset and	ateween d Death
	.O. Box 6	the death certifing the attending sched for use as	nysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal death	h 3⊟Ectopic pr 5⊟Other <i>(sp</i>				I	ate of delive	ery Day	Year
	ords, P	equires that en signed b	ρ	Part II. Other significant conditions	contributing to death bu	t not resulting :	in the underlying c	use give	n în Part I.		obacco use conf 'es 2□ No			death? ]Unknown
	<u> </u>	in; The law r ificate has be or, page 2 sh		25. Was case referred to medical							sy med? 2 <b>∑</b> No	Were autop prior to cor death? 1 ☐ Yes	psy findings mpletion of a 2□ No	s available cause of
		tending Physicia eath. tor: After this cert the funeral direct	ျှ	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b.	Time of 2 Injury M	3c. Injury Work 1 □ \	4 Li Nursing Ho		ence 6XIOth		) HOSP	PICE
i		pital or At urs after d eral Direct		4 ☐ Homicide determined	building, etc.	(Specify)				28f. Location (S City or Tow	n, State)			mber,
		the Hos iin 24 ho the Fund ppletely 1	ledica	one)						and due to the o	cause(s) and ma date and place,	and due to	ated. the cause(	(s)
0	)	To with	2	29b. Signature and title of certifier	2-		290	License	number	2	29d. Date signed	d (Month, I	Jay, Year)	_
									PTMONTING	MD 010	02	-/		
	4			31. Date filed (Month, Day, Year)	32. Registrar		Azada)	). <u> </u>	TIMONIUM,	MD 210	93		· · · · · · ·	

DHMH 17 Rev 1/2001

07-00468

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Darnell McCollum

		1-For State Certificate Registrar Certificate	e of Death		J. No 200	7 0105
Physicia		Decedent's Name (First, Middle,Last)  -		Date of Death     Month		3 Time of Death
ledical Exami	ner	Darneri Anton McCorrun		Month January 17		0737 hrs
		Facility Name (if not institution, give street and number)     Anne Arundel Medical Center	4b. City, Town, or Location of Dea	ath	4c. County of Death	
			Annapolis	. la participa	Anne Arundel	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 238-55-7903 1X M 2 F 32	· — — — — — — — — — — — — — — — — — — —	1 8. Date of Birth 09/04	(MM/DD/YYYY) 9. Birtl /1974 Co.	nplace (State or North <sup>Intry)</sup> Carolina
ę,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d Inside City Limits
_ **			gewater			1 Yes 2 X No
th the Maryland 23a or 28a-f show any notified at once.	햦	10e. Street and Number	10f. Zip Code	110	g Citizen of What Coun	
e Mai or 28	ie		· ·	100		пу.
ith th	al	1517   Arunde1   Road	21037  3. Was Decedent of Hispanic Origin? (	Specify Ves or No.	USA 14. Race - Americ	on Indian Plank
215-0036 be filed within 72 hours after death with the Maryland mal Hygien deher than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Funeral Director	1 Never Married 2 - Married Armed Forces?	If Yes, specify Cuban, Mexican, Pue		White, etc.	an indian, black,
ter de		Yes 241 No	Yes 2 X No specify:		Specify: B1	ack
15-0036 filed within 72 hours after a al Hygiene ed other than "natural", o rt, the Medical Examiner n	d b	or Dates:	edent's Usual Occupation (Give kind o	of work done	16b. Kind of Business/Ir	
72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DO NOT use r	etired)		,
036 thin ne	du	5+   You	uth Director		Church	
5-0( ed wi tygic other	Ö	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma		
MD 21215-0036 and 2 should be filed within 72 hours after alth and Mendal Hygievith man "matural", an matural", an matic event, the Medical Examiner	Be	Darnell Jerome Swiney	C:	larice McO	Collum	
	ျ		lailing Address (Street and Number of			
and 2 shot tealth and tem 27 is traumatic			17 Arundel Rd., Ed			
imore, MD 2 Pages 1 and 2 shou ment of Health and I tant: If item 27 is r or other traumatic			isposition (Name of cemetery, or other place)	Date	20c. Location - City or	own, State
more Pages 1 nent of H ant: If in		Total 2 Volcination 5 Transvarion state		21-07	Edgewater	. MD
Baltimore, permit. Pages I an Department of Hea Important: If iter		21. Signa of Funera per ce Licensee	22. Name and Address of Facility G		Kalas Funer	al Home
<b>m</b> a 2 <b>E</b> E		Muffeller	2973 Solomons Is:	Land Rd. I	Edgewater.	MD 21037
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enfailure. List only one cause on each line.				Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Cardiac arrythmia due t	to cardiomegaly			Death
-xammer		or condition resulting in death)  Due to (or as a consequence of):				
	L	Sequentially list conditions, b				<u></u>
	Examiner	if any, leading to immediate Due to (or as a consequence of):				
41	Cam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
ecuted and transit		d.				
ial ial	Medical	X unpended #23a,27, perME, g864, 2	2/21/07 TT			
760, icate be physici the buri	Ne	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
68 Sertifi	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Live birth 4 Pregnant at time of death	Fetal death 3 Ectopic preg	nancy	Month D	ay Year
Box 687 e death certific the attending	sic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
the d	Physician	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
s, P.O. Bedires that the deal signed by the a	þ			1 Yes	2 No 3 Proba	ably 4 V Unknown
(ecords, P.O. Box 68: The law requires that the death certificate has been signed by the attending age 2 should be detached for use as it	Completed			24a. Was ar	1 24b. Were auto	opsy findings available
of Vital Records, ng Physician: The law require offer this certificate has been sineral director, page 2 should be	Jple	<del></del>		autopsy perform	y prior to co	empletion of cause of
<b>P</b> - ,9 a	S			1 <b>✓</b> Yes 2		2 No
ital cian:	Be	25. Was case referred to medical examiner? Hospital: 1 Innation: 2 FB/Output	26 Place of Death (Chec			
Physic rethis	ဥ	1 Yes 2 No			esidence 6 Other	
1 of ting Pt After funeral		(Month, Day, Year)	e of Injury 28c. Injury at Work?	28d Describe ho	w injury occurred	
Sior vttend death ctor:	ati	2 Accident Investigation	1 Yes 2 No			
Division tal or Attendi rs after death.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc.	28f Location (Str or Town, Sta	reet and Number or Rur ate)	al Route Number, City
E 8 E	Cel	4 Homicide determined (Specify)  29a. Certifier A Continue Table 19 Continue Table 1				
	edical	(Check only Certifying Physician: To the best of my knowledge, death				
To the within 7 To the complet	ledi	and manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number		29d Date signed (Mon	th, Day, Year)
		Kamit Southall, mi	O.C.M.E.		January 18, 2007	
Ø		30. Name and address of person who completed cause of death (Item 23a)	444 B Ct B	ND 0400		
		Pamela E. Southall, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Street, Baltimore	, IVID 21201		
Si Regis	tate trar	10 to 5 2007   Maria 18 24	medil			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Charles 11:10 AM Nau January 18 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Maryland Medical of Center Baltimore, Mary land If Under 1 Year If Under 24 Hrs 6. Sex 8. Date of Birth (Month, Day, NOV 3 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Nov. Days Hours <sup>4</sup>925 1 M 2 □ F Maryland Director 217-36-4158 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must however. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Kent Kennedyville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21645 12655 Augustine Herman Hwy. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2X No Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dairy, Beef Elementary/Secondary (0-12) College (1-4or 5+) Farmer & Grain Farming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Jackson Elmer Nau 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12655 Augustine Herman Hwy. Kennedyville MD Elizabeth A. Nau (wife) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/20/07 Galena Cemetery Galena, MD. 4 ☐ Donation 5 ☐ Other (Spepity) 21. Signature of Funeral Service Lico 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 234 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TRAUMATIC Physician BRAIN INJURY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform page 2□ No 1 ☐ Yes 2 K No 1☐ Yes or Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ¥Yes 2 No 1 ZInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 Pending investigation 1 □ Natural January 17,2007 STairs Fall down 15:00 or ... ./s after dea. \*al Director: ♪ M 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

105 Place of injury - At home, farm, street, factory, office building, etc. (Specify)

106 Place of injury - At home, farm, street, factory, office building, etc. (Specify)

107 Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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109 Place of injury - At home, farm, street, factory, office building, etc. (Specify)

109 Place of injury - At home, farm, street, factory, off 3 ☐ Suicide 4 Homicide n 24 hours the Funeral Dire 29a, Certifier (Check only within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of certifier 18,2007 MD. 200081 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Youssel 22 S Greene STreet BALTIMOKE, MD 21201 31. Date filed (Month, Day, Year) 32 egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1- State of Mar Registrar		artment of H		Mental Hygie	ene 007	01961
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici		Eduardo Julio Osorio				Month January	Day Year 5, 2007	11:56 <sup>p м</sup>
Y	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De		4c. County of Deat	
	LAUITIN		Holy Cross Hospital		Silver S	nring		Montgo	marii
-10	Funeral			In yrs. last birthday)	If Under 1 Year	If Under 24 H		9. Birt	hplace (State or Foreign
	Director		053-76-2884	69 Yrs.	Months Days	Hours Mi	n. (Month, Day, Y March 19,		<i>intry</i> ) <b>i1</b> e
2			Usual Residence of Decedent	33			march 19,	_1937 CII	TT6
	ylan Jow		10a. State 10b. County 1	0c. City, Town or Loc	cation				10d. Inside City Limits
	Mar a-f st	ţ	Maryland Montgomery	Kens	sington				1 ⊡Yes 21 No
	r 28g	Director	10e. Street and Number	KEII	10f. Zip Code		10g	g. Citizen of What Co	
	h wit	<u>=</u>	3509 Nimitz Road			20895		Chil	е
	deat	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13. V	Was Decedent of His	spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame	
9	after or ite	교	1 Never Married 2 1 Narried 1 Yes, Give		i Sayes 2 No			Black, White	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the M-dical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		it Mg res 2 ⊡ 110	Specily.	Chilean	Specify: Wh	ıte
2-0	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ation	vorking 16	6b. Kind of Business/	Industry
21	e. an "	ldr	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done d OO NOT use retired;	)	, sixing		
	er th	lo Co	10	Mechar	nic			tomobile	
p	be filed within 72 hours after death with the Marylar ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the M-dical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)				ame (First, Middle, Ma	aiden Surname)	
<u>ya</u>	Men arke	ျဉ	Unknown Osorio				nknown		
Baltimore, Maryland	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injuy or other traumatic event once.		19a. Informant's Name/Relationship (Type. Print)  Eduardo F. Munoz/ Friend		-		Rural Route Number, (		Zip Code)
2	and ealth m 27					ad, ken	sington, M		
ore	jes 1 t of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ি Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, cren	sition (Name of natory or other place	e) Ta	nuary 10	Oc. Location - City or	Town, State
ے ہ	Pag ment ant: uny			Metropolit		tory	2007 A		, Virginia
() E	permit. Depart Import any inj once,		21. Signature of Funeral Service Licensee	F3	Name and Addres	s e & Fiftin	s Funeral	Home Inc.	00001
. Ш	207 2 2 2		James & John	50	JU Univer	sity BI	vd, W., Si	Iver Sprin	ng,MD 20901
		8	23a. Part1 Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	er the mode of dying	g, such as card	iac or respiratory arres	t,	Approximate Interval Between
10	Physician		Immediate Cause (Final disease or condition Acute My	ocardial 1	Infarction	n			Onset and Death
	/Medical			consequence of):	1111010010				
	Examiner		Sequentially list conditions b. Atherosc	lerotic He	eart & Ve	ssel Di	sease		
Sh.	₽ .≅	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):					
	ecute ind trans	am	that initiated events c.						
Ö,	e excilan a		Due to (or as a	consequence of):					
8760,	or Attending Physician: The law requires that the death certificate be executed interdeath.  Director: After this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit.	dical	d						
9	ing p	Mec	IF FEMALE:						
Вох	leath certific attending p	an/	23b. Was decedent pregnant 1 Live birth 2	☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date of del Month	ivery Day Year
	e deg	sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at till 9 ☐ Unknown 9 ☐ Unknown	ne of death 5 □	Other (specify)			Wildian	Day Tour
P.0	that the de led by the a detached	Physician/Me				n in Dadd	OGo Didasha		Alter annual of do ath 2
Ś	res tha iigned be def	þ	Part II. Other significant conditions contributing to death but	lot resulting in the ur	idenying cause give	min Panti.			the cause of death?
5	w requir been s should	ted			<del></del>		- To res	2 No 3 Pr	obably 4 Nunknown
ပ္ပ	e law r has be je 2 sh	ble					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Vital Records,	The Late ha	Completed					performe	ed? death? ▼No 1 □ Yes	
İta	sician; Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
	hysic this ce al direc	10E	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing	Home 5 ☐ Residen	ce 6 ☐Other (Spe	cify)
0	ding Ph .r After thi funeral		27. Manner of Death  ★★Natural 5 Pending 28a. Date of Injury  (Month, Day 1)	28b. Time of Injury	28c. Injury Work	at	28d. Describe how	injury occurred	
. <u>ō</u>	ath. ath. or: Al	atio	2 Accident investigation		M 1 🗆 1	res 2 □ No			
Division or	If or Attend after death, Director; /	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc.	- At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	Ital or rail Di	Certification:							
	Hosp 4 hou Fune ely fil	ledical	29a. Certifier (Check only 1 ☑ CertifyIng Physician: To the best of 2 ☐ Medical Examiner: On the basis of e						
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medi	one) and manner state						
		2	29b. Signature and title of certifier		29c. License	number	290	d. Date signed (Mont	
	3		In Huyen M.	2	100	0 19	7241	1-9-	2607
			30. Name and address of person who completed cause of dea		Print)	n ve.L	Class Del	c.1c	
			31. Date filed (Month, Day, Year)  32. Degistrar	TIERO s Signature	1 1000 1	V197 (	Sten Rd.	SI I VCL 3P	HAS, ME
	Sta Registi		JAN 1 0 2007	. 1. A.	antis				20710

			1 - For State Registrar	State	e of Maryl	and / Depa	artment rtificate			nd M		iene eg. No. 20	07	01962
	Physici	an	Decedent's Name (First, Middentification)								2. Date of Dear Month	Day	Year	3. Time of Death
	/Media	al	LOUIS HENRY				45 City T		Location of	Dooth	Jan	3 20 4c. Count	007	8:00 PM <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution Genesis Heal			Dinos	46. City, 1		Location of	Death			albo	
	Funeral		5. Social Security Number	6. Sex	7. Age (/n)	rs. last birthday)	If Under	1 Year	ston If Under 2		8. Date of Birth			place (State or Foreign
	Director		220-03-8952	1 <b>X</b> M 2□	F 8	5 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, JAN 2,	1922	MAR	YLAND
	and **		Usuel Residence of Decedent  10a, State 10b, Count	у	10c.	City, Town or Lo	cation							10d. Inside City Limits
	Maryl	힏	MD T	'ALBOT		1	ASTON	i						1 ☐ Yes X☐ No
	ith the Marylar or 28e-f ahow is notified at	Director	10e. Street and Number	динох			10f. Zip				1	0g. Citizen of	What Cou	untry?
	th witi		#16 PARK LAN	Œ				21	1601				U	SA
nson <b>21215-0036</b>	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or Itams 23e or 28e-1 ahow umatic event, the Macical Exempter court be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	rried Arme	Decedent Ever i d Forces? 'es 2 ☐ No i, Give or Dates:		Was Decede If Yes, speci 1 Yes 2	_		in? (Spe Puerto	ecify Yes or No- Rican, etc.)		ck, White	rican Indian, , etc. HITE
<u>5</u> -0	natu	lete	15. Decede (Specify only high	nt's Education est grade comple	ted)	(Give	dent's Usual kind of worl DO NOT use	k done d	uring most	of worki	n <i>g</i>	16b. Kind of B	Business/I	ndustry
120	withir ene. then	Completed	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+)		CHUTE					v.s.	NAVY	
d D	Hygother other	Be C	17. Father's Name (First, Middle	, Last)			JHU Z Z	T		's Name	(First, Middle,			
S Parkin	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avant, the MODE.	To E	HERMAN LOUIS  19a. Informant's Name/Relation			19h Mailie	ac Address	(Street a			NN WHIT			in Code)
S P	and 2 s ealth an n 27 is i		CINDY MOSSI/G						_		AYTONA I			
-H 40	of Hee		20a. Method of Disposition  1 ★ Burial 2 □ Cremation	2 Damoual 6	- 1	b. Place of Dispo	sition (Nam	e of	-		10 mm	20c. Location		
Lou	Pages ment of ant; if it ury or o		4 Donation 5 Other (			MD VETER	RANS C	EM		01/09	9/2007	HURLOC	к. м	D
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service	01	15 C.F.	F	LLOWS	, Hi	s of Facility	EIN	& NEWNA	M FUNE	RAL	
	Physician		23a. Part1. Enter the disease, on shock, or heart failure. List immediate Cause (Final disease or condition	or complications th	nat caused the c									Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due	e to (or as a con	sequence of):	Symi	dra	ma					Mesns
Щ		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. /1/2	to (or as a con		2911	V KIN						Jews
8760,	ate be executed hysicien and the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	e to (or as a con	sequence of):								
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	quires thet an signed b ruld be deta	þ	Part II. Other significant condit	10321	to death but not	resulting in the u	nderlying ca	use give	on in Part I.			bacco use con es 2□No	tribute to 3 ☐ Pro	the cause of death?
eco	ne law re has be	Completed	Dinbetesn	rellitus							24a. Was a autops		prior to c	topsy findings available ompletion of cause of
- X	The page	Con									perfor	ned? 2 No	death?	2□ No
Vita	Iclan certifi ector	æ	25. Was case referred to medic examiner?	Hospital				Othe	-		(Check only on	*		
Division of Vital Records,	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page	ıtlon: To	1 Yes 2 No  27. Manner of Death Natural 5 Pend 2 Accident inves	28a. C	1   Inpatient 2   EN/Outpatient 3   DOA   Nursing Hon				ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred					
Divis	tal or Attai s after dea al Diractor ed in by the	Certification;	3 Suicide 6 □ Could	mined 286. F	Place of Injury - / puilding, etc. (Sp	At home, farm, str pecify)	reet, factory,	office			28f. Location (Si City or Town		ber or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) Certify	ing Physician: To I Examiner: On to and	o the best of my he basis of exar manner stated.	knowledge, deat nination and/or in	h occurred a vestigation,	it the tim in my op	e, date and pinion, deat	i place, a	and due to the c ed at the time, d	ause(s) and mate and place	anner as , and due	stated. to the cause(s)
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0	10+VA 70+VA		30. Name and address of perso	n who completed	cause of death	(Item 23a) (Type,	Print)	ma	n's L	PALIS	! F.	STOWN	mn	21601
	Sta		31. Date filed (Month, Day, Yea		32 egistrar's S	ignature	U 1 C/1	[1 · (12])	NJA	· /131	- ~	171010		Q T U U
	Regist	rar	JAN 0 8	3 2007	Billion	BA	30							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amended item 01/05/07,TCHD,sr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12:00A M ROBERT ERNEST PRITCHETT 01 03 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Oueen Annes ir If Under 24 Hrs. 8 s Hours Min. 13404 Talbot Cannery Road If Under 1 Year | I Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 X M 2 □ F 65 yrs. Director 01 - 11 - 1941Maryland 217-36-2241 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits show in than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Directo Maryland Talbot Queen Annes 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21657 USA Funeral 13404 Cannery Road within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens important: if item 27 is marked other that any injury or other traumatic const 11 Fork Lift Driver S.E.W. Friel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Raymond Nichols Elizabeth Pritchett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daisy Pritchett / wife P.O.Box 185, Queen Annes, Maryland 21657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) une of Fundal Service Licensee 01/13/ 07 Sandtown Cemetery! Hillsboro, Maryland 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailure. MINUTER to Acuta Priysician disease or condition resulting in death) /Medical , Hour Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ঠ Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown leted 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Compl autopsy performed 1 Yes 2X No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29b. Signature and title/of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15029

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month Date)

Woldsdan MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2007

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istrar's Signatur

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4:00 a M Palella January 15, 2007 Frank /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country)

Sept. 22,1919 New York Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 ☐ F Director 87 102-10-7915 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Calvert North Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20714 864 Bay Front Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician **Electrical** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertini Palella Concetta P Latterio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 864 Bay Front Avenue, North Beach, MD 20714 Lucille Johnson/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State to 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I eny injury o once. 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 1/20/2007 Berlin, New Hampshire 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Parkinsons Physician isease months /Medical Due to (or as a consequence of): Examiner rus - Adult onset Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed (lancer 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has rector, page 2 s autonsy perform rombocy topenia 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director: , 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License numbe 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co Suite #205 110 Hospital road 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JAN 1 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** рм Hampton Lee 6, 2007 7:10 Peed, January Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8715 First Avenue, #509D Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 1 M 2 □ F Yrs. Director 577-40-3850 76 20, 1930 Washington, DC Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e r items 23a c 8715 First Avenue, #509D 20910 USA death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iten ury or other traumatic event, the Medical Examiner 1 Never Married 2 Married <sub>Specify:</sub> White 1 ☐ Yes 2 No If Yes, Give Year or Dates: Korea Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Hampton Lee Peed, Sr. Sophie Elizabeth Williams ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allison C. Kelley/ Niece 12723 Turquoise Terrace, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 15, Jan. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 2007 Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Kechard 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Coronary Artery Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the bunal-transit Multiple Myeloma Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) been signed by the should be detached ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2€XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ha perform 2 No 1 Yes 1☐ Yes 21 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 StResidence 6 Other (Specify) 1 Yes 2√2 No 1 Inpatient 2 ER/Outpatient 3 DOA this ( 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death.

I Director: A
od in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral D

completely filled in To the Hospital 松公certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -27660 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Alpana Goswami,

**JAN 10** 

31. Date filed (Month, Day, Year)

M.d

2007

Pagistrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

1/1/125 Rockville Pike, Suite 110, Rockville, MD 20852

			For State Registrar	State	of Maryla	-	artment of F rtificate of		Mental Hy	giene 2	007	01966
	10 mg - 11	Э	Decedent's Name (First, Middle)	Last)					2. Date of De	ath	Voor	3. Time of Death
	Physicia /Medic		Robert James I	Peake						ry 6, 2	Year 2007	2:58 am
	Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town, o	r Location of Dea	th	4c. Cour	nty of Death	h
el ÷	440		Holy Cross Hos					r Spring			ntgom	
	Funeral			6. Sex 1 X M 2 ☐ F	7. Age (In yi	rs. last birthday, 71 <sup>Yrs.</sup>	If Under 1 Year   Months   Days	If Under 24 Hrs Hours Min	. (Month, Da	ay, Year)	Co	nplace (State or Foreign untry)
	Director	}	577-44-4249 Usual Residence of Decedent		<u> </u>	71			June 20	), 1935	was	hington, DC
	/land ow at		10a. State 10b. County		10c.	City, Town or L	ocation					10d. Inside City Limits
	Mar a-f sh	혅	Maryland Montq	omery		Silve	er Spring					1 ∐Yes 24 ∐No
	th the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Co	untry?
	hours after death with the Maryland tural", or Items 23a or 28a-f show at Examiner must be notifited at		11302 Kenton	Place			20902			US		
	tems	Funeral	11. Marital Status	Armed	cedent Ever in Forces?	U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		lace - Amei lack, White	rican Indian, e, etc.
30	s afte	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, C	2 □ No Give Dates: 1955		1 □ Yes 🔏 🛱 No	Specify:		Spec	c <i>if</i> Whit	.e
2-003p	hour Itural		15. Decedent		Dates: 1953	16a. Dece	edent's Usual Occup	pation		16b. Kind of	Business/	Industry
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7 7	yiene giene rrtha the	mo	12	College	(1-401 5+)	S.	teamfitte	r		Hea	ting	& A/C
and	al Hy othe	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	ıme (First, Middle	, Maiden Surn	ame)	
<u>a</u>	Menta Menta arked atic e	2	Robert James P	eake				E	thel Lou	ise Co	rrido	n
Mar	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsh				ing Address (Street					
	and lealth m 27 her tr		Muriel M. Peak	e/ wire	1201		2 Kenton		Date SI	20c. Locatio		
aitimore,	ges 1 If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	m State	cemetery, cre	osition (Name of ematory or other pla		uary 12	200. Locatio	II - City of	Town, State
≣	t. Pa rtmer rtant: rjury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service		Me		an Cremator	У :	2007	Alexan	dria,	Virginia
Ra	permit, Pages 1 Department of I- Important: If Ite any injury or ot		Turband I	4 (		1	22. Name and Addre Francis J 500 Unive	Collin	s Funera	al Home Silver	Inc.	ng, MD 20901
		-	23a, Part1, Enter the disease, or	complications tha	t caused the de						_ pri	Approximate Interval Between
	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause or	n each line.							Onset and Death
	/Medical		disease or condition resulting in death)  a. Fluid and Floctrolyte Depletion  Due to (or as a consequence of):							1_Week		
	Examiner		Sequentially list conditions b. Diarrhea								3 Months	
		Jer	Sequentially list conditions, if any, leading to immediate	if any leading to immediate Due to (or as a consequence of)							- 5	5 11011 (110
	cuted nd ransit	Examine	Cause (Disease or injury that initiated events				ory Bowel	Disorde	r			13 Years
Ö,	be executed sician and burial-transit	EX	resulting in death) Last	Due t	to (or as a cons	sequence of):						
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9 ×		/Me	IF FEMALE:	23c. If yes. o	outcome pf pre	gnancy				224	Date of del	ivon
. Box	eath catternation	Sian	23b. Was decedent pregnant in the past 12 months?	1□Liv	e birth 2 DF	etal death 3	☐Ectopic pregnand	СУ			Month	Day Year
O.	at the de by the	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9□Unl		01 404						
<u> </u>	The law requires that the death certifite has been signed by the attending to age 2 should be detached for use as	y Ph	Part II. Other significant condition	ons contributing to	death but not	resulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use co	ontribute to	the cause of death?
<u>5</u>	quires n sign ald be	d by	Chronic Obstruc	tive Pul	monary	Diseas	e		, PE	Yes 2 □ No	) 3 □ Pr	robably 4 □Unknown
Records,	aw require s been sig should b	Completed							24a. Wa		b. Were au	utopsy findings available
	The late has age 2	E O							perl	opsy ormed? 2 □ No	death?	completion of cause of 2⊠Xto
Vita		BeC	25. Was case referred to medical					26. Place of De	eath (Check only			
	Physician: r this certific ral director,	To E	examiner? 1 ☐ Yes — 2 <b>∑M</b> No	Hospital: 1 [	<b>X</b> 3npatient 2	2 ☐ ER/Outpatie	ent 3□ DOA Ot	her: 4 \(\sum \) Nursing	Home 5 ☐ Res	idence 6 🗆	Other (Spe	cify)
0	ng Phy ifter thi ineral		27. Manner of Death 1XXIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	/8.6	te of Injury onth, Day Yea	r) 28b. Time Injury	Wo		28d. Describe	how injury occ	curred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investig 3 Sulcide 6 Could	ation		Thems from a		]Yes 2□No	00/ 1	(Ottd N		A Device Manager
Division or	or Attendated death Director:	Certification:	4 Homicide determ	inod 200. Fld	ice of injury - A ilding, etc. (Sp	ecify)	street, factory, office		City or To	(Street and Nu own, State)	mber or Hi	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 🕶 Certifyin	g Physician: To	the best of my	knowledge, dea	ath occurred at the t	time, date and pla	ce, and due to the	e cause(s) and	manner as	s stated.
	e Hos 24 h e Fun letely	Medical		Examiner: On the			investigation, in my					
	To the To the To the To the Sormp	Me	29b. Signature and litle of conflie	1/21	. //		29c. Licen	se number		_		th, Day, Year)
			- Andrian	Vella (1)	4			D02338		J	anuar	у 9, 2007
	1011		30. Name and address of person	who completed ca				***				
			Richard Delaney				Drive, Wh	eaton, M	ID 20902			
	Sta		31. Date filed (Month, Day, Year)  JAN 1 0		Registrar's S	ignature	Carpo					
	Regist	re li	OHII I O	2001	S. M. S. S. S. S.	10 10						

07-00091 In Hwa Park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) Date of Death Physician/ Month **Medical Examiner** In Hwa Park 2134 hrs January 3, 2007 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 9314 Cherry Hill Road #427 College Park Prince George's 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Months Days Hours Director 212-61-0970 1X M 36 June 8, 1970 Korea 2 Country' Usual Residence of Decedent È 10c. City, Town or Location 10d Inside City Limits 10a. State 10b County 28a-f show Yes 2 X No hours after death with the Maryland Maryland Director Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 17506 Gallagher Way 20832 Korea Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black Armed Forces? 1 X Never Married 2 Married White, etc. 2 X No 9 Yes spAs,ian 1 Yes 2 X No specify. 3 Widowed 4 Divorced If Yes Give Year ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) be filed within 72 traumatic event, the Medical Student Community College 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Kook Won Park Yoon Ja Kwak æ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DaeHwa Park/ Brother 17506 Gallagher Way, Olney, Maryland 20832 20a. Method of Disposition 20b Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State timore, ury or other crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Jan. 11, Gate of Heaven Cemeter Jepartment mportant: Donation 5 Other Specify 2007 Silver Spring, Marylan 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 Signature of Funeral Service Licensee iand Z 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure List only one cause on each line Between Onset and /Medical Death a. Intracranial Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and The law requires that the death certificate be executed cal attending physician or use as the burial -UNPENDED AMENDED Physician/Medi Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I o 23e Did tobacco use contribute to the cause of death? ģ σ. 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26 Place of Death (Check only one) æ Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this ✓ Yes No After 1 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: ✓ Natural Pending Yes 2 No Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) OCME January 4, 2007 rasse 30 Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registrar

31 Date filed (Month

Registrar's Signat

2007

			For State of Maryland / E State of Maryland / E Registrar	Department of Health an Certificate of Death	ıd Mental Hygien Reg. N	2007 01069	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death	
	Physicia /Medic		Ida A. Prysock		January	21, 2007 7:21 P M	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D	Death 4	4c. County of Death	
	ite.		College View Center  5. Social Security Number 6. Sex 7. Age (In yrs. last bir	Frederick  thday) If Under 1 Year   If Under 24	Hrs. 8. Date of Birth	Frederick	
	Funeral Director		104 087		Min. (Month, Day, Yea		
×	ъ		Usual Residence of Decedent		NOV. 11,	1911 West Virginia	
	trylan show	L	10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits	
2	Ba-f s	Director		derick		1 ⊠ Yes 2 □ No	
	with the	Ē	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?	
	eath	Funeral	1478 Mobley Court  11. Marital Status 12. Was Decedent Ever in U.S.	21701		United States  14. Race - American Indian.	
20	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If health and Mental Hygiene, and The Maryland T is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fun	Armed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  1 ☐ Yes 2 ☒ No Specify:	Puerto Rican, etc.)	Black, White, etc.  Specify: White	
5	72 hou		15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation	16b.	Kind of Business/Industry	
7	ithin 7 le. lan "r Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired)	working		
V	led will lygier the he		4	Teacher		ementary School	
2	ntal F ed otl	Be	17. Father's Name (First, Middle, Last)		Name (First, Middle, Maide	•	
Ž	in Me id Me mark matic	မ	David Watson Fyfe  19a. Informant's Name/Relationship (Type. Print)  19b	. Mailing Address (Street and Number o	Emma Fische		
<u>2</u>	nd 2 s lith ar 27 is r trau		.   .   .   .   .   .   .		rederick, Ma	·	
ת ת	s 1 and of Head		20a. Method of Disposition 20b. Place of	Disposition (Name of	Date 20c.	Location - City or Town, State	
2	Pages nent of int: If its iry or o		Per Bunar 2 Cremation 3 Chemoval from State	nc Mem. Gardens	anuary 25  2007   Ke	eyser, West Virginia	
מפור	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		21. Signal re of Funeral Service Licensee	22. Name and Address of Facility	Stauffer Fun	eral Homes, P.A.	
	O					cick, Maryland 21702	
		S (	23a. Part1. Enter the disease, of complications that caused the death. Do r shock, or heart failure. List only one cause on each line. Immediate Cause (Final	lot enter the mode of dying, such as cal	rdiac or respiratory arrest,	Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death) aue to (or as a consequence	<i>S G</i>			
	Examiner		Due to (or as a consequence of	л).			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):			
	ocuted nd transii	Examiner	that initiated events c.				
Ć,	iicate be executed physician and s the burial-transit	EX	resulting in death) Last Due to (or as a consequence of	of):			
00/00	physicate to the control of the cont	edical	d				
Š	certifi nding use as		IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery	
ŏ	death	Physician/M	in the past 12 months?  1 Ves 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year	
Ş	t the by the tacher	hys	9 ☐ Unknown 9☐ Unknown				
colds,	The law requires that the death certificate be executed its has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not resulting in		id tobacco use contribute to the cause of death?  ☐ Yes 2☐ № 3☐ Probably 4 ☐ Unknown		
5	aw re is bee 2 sho	plet			24a. Was an	24b. Were autopsy findings available	
	ding Physician: The lav n. After this certificate has funeral director, page 2:	Completed			— autopsy performed? 1□ Yes 2□→		
פ	clan: ertific ector,	Be (	25. Was case referred to medical examiner?		Death (Check only one)		
5	Physical this call dire	2	1   Yes 2   No Hospital: 1   Inpatient 2   ER/Ou		ng Home 5 Residence		
	ding I	ion:	1 → Matural 5 Pending (Month, Day Year)	Fime of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	jury occurred	
2	Atten death ctor: y the	ficat	3 Suicide 6 Could not be 28e. Place of injury - At home, fa		-	and Number or Rural Route Number.	
Ś	al or saffer	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	ate)	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	, death occurred at the time, date and p d/or investigation, in my opinion, death	place, and due to the cause occurred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)	
	To the within To the Comp	M	29b. Signature and title of certifier	29c. License number	29d. I	Pate signed (Month, Day, Year)	
1			) IV	D006041	7   [/	22/07	
	(H)		30. Name and address of person who completed cause of death (Item 23a) (		_		
	()		1. Date filed (Month, Day, Year) 32. Registrar's Signature	ias Johnson to	V. Freder	11'CC MO 21702	
	Sta Registr		31. Date filed (Month, Day, Year) 22. Registrar's Signature	back 1			

		,	1 - For State Registrar		of Marylar			nt of H te of L		ind M		giene Reg. No:			969
	Physicia /Medic		1. Decedent's Name (First, Midd Ewdokia	Rys	chenko	W					2. Date of De Month Jan	Day	007		e of Death
	Examin		4a. Facility Name (If not institution  Montgomery	_		al	1	, Town, or Lney	Location of	f Death			County of D	eath omery	
	Funeral Director		5. Social Security Number 579-50-9149	6. Sex 1 □ M 2 □ F	7. Age (In yrs. 88	last birthday, Yrs.	Months	or 1 Year Days	ff Under 2 Hours	Min.	8. Date of Bir (Month, Da 3 / 1 4 /	191	9. 8 F	Birthplace (Sta Country) Russia	te or Foreign
	e Maryland	ctor	Usual Residence of Decedent           10a. State         10b. County           MD         Mont	gomery		ty. Town or L lver		ing							e City Limits Yes 2 💆 No
	h with th	al Dire	10e. Street and Number 3501 Forest	Edge Dr	rive #3	BC .		ip Code 2090	6			10g. Citi	zen of What USA	Country?	
036	be filed within 72 hours after death with the Maryland ald Hyglene.  Ald Hyglene.  Ald Hyglene.  Bee'l show world the Madical Examinar must be notified at event, the Madical Examinar must be notified at	Be Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☐ Widowed 4 ☐ Divorce	rried Armed F	2 <b>⊠</b> No iive	J.S. 13.	Was Dec If Yes, sp	ecify Cuba	spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)			merican Indiar Thite, etc. Thite	٦,
21215-0036	d within 72 ho giene. rr then "natur the Madical	ompleted		nt's Education est grade completed College 5 H	) (1-4or 5+)	16a. Dece (Give life.	o kind of w DO NOT	ual Occupa rork done d use retired	luring most )	of working	g	16b. Ki	nd of Busine		
ᅙ	m - 0 5	To Be C	17. Father's Name (First, Middle, Ilya Sazaro	tny					Na	atal	(First, Middle, ya Sa	zaro	otny		
e, Mar	permit. Pages 1 end 2 should by Department of Heatils and Menta Importent: If item 27 is marked eny Injury or other treumatic ev once.		19a. Informant's Name/Relation Serge Chern				10 A	meri		Rive	Route Number Dri	ve	Sacr	amento 9586	54
Baltimore,	it. Pages rtment of h rtent: if its njury or of		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3  21. Signature of ☑ Pareral Service	Specify)	State	cometery, cre Rock (	matory or Cree.	other place k Cei	m. 1/	/10/	07	Was	sh.,D		
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	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on	each line.		iter the mo	ade or ayını	g, such as c	cardiac or	respiratory a	rrest,			Between nd Death
8760,	ste be executed hysiclen and the burial-transit	Ilcal Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>Ś</b> c	o (or as a consec										
P.O. Box 6	The law requires that the death certificete be executed tie has been signed by the ettending physicien and bage 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live	utcome of pregni birth 2 Feta Inant at time of conown	al death 3[	⊒Ectopic ⊒ Other (s	oregnancy specify)				4	23d. Date of Month	delivery Day	Year
	w requires that been signed to should be dete	þ	Part II. Other significant conditions remained fair						en in Part I.			obacco u Yes 2[		to the cause Probably 4	
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<u> </u>	Physician: this certifics at director,	Be	25. Was case referred to medica examiner?	Hospital:				Othe			(Check only o				
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DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could 4 Homicide deterr	nined 286. Place	e of Injury - At h ding, etc. (Special	ome, farm, st	reet, facto	ry, office		2	8f. Location (: City or Tox	Street and vn, State,	d Number or	Rural Route N	Number,
	ne Hospi n 24 hou ne Funer detely fill	Medical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the Examiner. On the and ma	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	th occurre rvestigatio	d at the tim n, in my op	e, date and pinion, death	l place, a h occurre	nd due to the d at the time,	cause(s) date and	and manner place, and	as stated. due to the caus	se(s)
	To the To the comp	Ž	29b. Signature and title of certific					oc. License						onth, Day, Yea	
	4	į	30. Name and address of persor	who completed cau	se of death (Iter	m 23a) (Type,	Print)	-	8542					9,200	
			Libuje  31. Date filed (Month, Day, Year	Heinz-M					Geo	rgia	a Ave	#51	5 Whe	aton,	Md 902
	Sta Registr		JAN 1 0		Hegistrar's Signa	ature /	will							20	J U Z

DHMH 17 Rev 1/2001

3. Time of Death

2. Date of Death

Physician	
/Medical	
Examiner	

	sician edical	HELEN	B. RICHA	RDSON							JANUARY	. Bay	2007	4:30 PMM
	miner	4a. Facility Name (If	not institution, giv	e street and nu	umber)			4b. City, Town, o	r Location	ot Death		4c.	County of Deatl	1
			HOSPICE						STON				TAI	LBOT
Funer Direct		5. Social Security Nu 216-05-0		Sex 1 □ M 2 😿 F	7. Age	(In yrs. last birt	hday) Yrs.	Months Days	If Unde Hours	Min.	8. Date of Birth (Month, Day FEB 4,	191	9. Birth	hplace (State or Foreign
, g		Usual Residence of 10a, State			-	10a City Tay								404 1 12 0 1 1 12
anyla ehov	5		10b. County	Mr.		10c. City, Town		ation						10d. Inside City Limits 1 ☐ Yes 2 ▼No
death with the Maryland ms 23a or 28a-f ehow	Director	MD	TALBO	) <u>T</u>		EAST	UN	1 1 2 2 2						
with t	급	10e. Street and Num						10f. Zip Code				10g. Citiz	zen ot What Co	
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5 E 6	Funeral	11. Marital Status 1 ☐ Never Marrie	ed 217 Married	Armed F	orces?		lt.	as Decedent of H Yes, specify Cuba	an, Mexic	an, Puerto R	lican, etc.)		Black, White	
5-UU36 72 hours after deat netural', or items ?	À	3 ☐ Widowed		It Yes, G Year or I	IVe		1	☐Yes 21X No	Specif	y:			Specify: WH	ite
D 2 2	ete	(Speci	15. Decedent's E- fy only highest gra	ducation ade completed,	)	16a.	(Give h	ent's Usual Occup	during mo	st of working	g	16b. Kir	nd of Business/l	ndustry
withir then	Completed	Elementary/Secon	ndary (0-12)	College (	(1-4or 5-	<b>-</b> )		O NOT use retired DMI NI STR				E	DUCATIO	N
	Φ	17. Father's Name (	First, Middle, Last	)						her's Name	(First, Middle,			
C E B E	ToB	THOMAS	P. CASSI	DY						OTHE	LIA C.	EUR	LICH	
		19a. Informant's Na	me/Relationship (	Type, Print)		19b.	Mailing	Address (Street	and Num	ber or Rural	Route Number	r, City or	Town, State, Z	ip Code)
and 2 st selth and n 27 ie n		NORBERT	J. RICHA	RDSON/1	HUSB	AND   78.	56 1	WOODLAND	CIRC	LE, E	ASTON,	MAR	YLAND 2	1601
S T T T T		20a. Method of Disp	osition Cremation 3	Removal from	State	20b. Place of cemeter	Dispos y, crem	ition (Name of atory or other place	ce)	Da	ate	20c. Lo	cation - City or	Fown, State
tent:			5 Other (Specif	-		DRUID		GE CEMET	-		/2007	BALT	TIMORE,	MARYLAND
Baltimor permit. Pages Depertment of I importent: if its any injury or o	g	21. Signature of F	ral Service Li	se //		11	22.	Name and Addre	ss of Fac	NRETN	e nighn	AM I	TA SISTATIS	HOME PA
4 40:4	a	23a. Part1. Enter th	///	Mar										
		shock, or hear	t tailure. List only	plications that one cause on	each line	the death. Do n	ot ente				respiratory arr	rest,		Approximate Interval Between Onset and Death
Physicia	_	Immediate Cause (I disease or condition resulting in death)	Final 1	ur	oth	relia	_	Carcin	nom	0				( mos
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os / ou fficate be e physicier as the buria	ig			_ d										
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BOX leath cer ettendin I for use	ciar	23b. Was decedent in the past 12 r	months?	1 ☐ Live	birth 2	Fetal death		Ectopic pregnancy Other (specify)	/			-	3d. Date of deli Month	Day Year
<b>5</b>	) ys	1 □ Yes 2 □ 9 □ Unknown		9□ Unkr										
BCOTGS, F.C. law requires that the as been signed by t 2 should be detach	y Ph	Part II. Other signifi	cant conditions	contributing to	death bu	t not resulting in	the un	derlying cause giv	en in Parl	I.	23e. Did to	bacco u	se contribute to	the cause of death?
COLDS  * requires been sign should be	d by	Chron	ric k	ione	24_	Dise	2 se				1 🗆 Y	es 2[	No 3∏Pro	obably 4 Unknown
W rec	Completed	Hugo	Hons	im							24a. Was a	en .	24b. Were au	topsy findings available
9 a a a a	Ĕ	11/1	0 /								autops	sy med2	prior to c death?	completion of cause of
VICAL P ician: Th certificate ector, pag	ပိ	25. Was case referre	ed to medical						ac Dia	as at Dooth	1 ☐ Yes (Check only or	2 X No	1 ∐ Yes	2□ No
	9	examiner?		Hospital:	Inpatien	nt 2 🗆 ER/Out	natient	3□ DOA Oth					Other (See	HOSPICE
		27. Manner of Death		28a. Date	of Injun	, 28b. T	ime of	28c. Injur			Bd. Describe he			" HOSPICE
VISION Attending r death. ector: After by the fune	atio	1 □Natural 2 □ Accident	5 Pending investigation		nth, Day	rear) in	ijury		Yes 2	□No				
JIVISION I or Attending efter death. Director: Afte	. E	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	289. Plac	e ot tnju	ry - At home, tar (Specify)	m, stre	et, factory, office		28	Bt. Location (Si City or Town			ral Route Number,
s effection	Certification:			Julia	arry, otc.	. (ороспу)					Only or Town	n, State)		
LIVISIO  To the Hospital or Attendi within 24 hours elter death.  To the Funeral Director: A completely filled in by the fi	Medicai	29a. Certifier (Check only one)	1 Certifying Pt 2 Medical Exam	miner: On the t	e best of basis of	examination and	death	occurred at the tinestigation, in my o	ne, date a pinion, de	and place, ar	nd due to the c d at the time, d	ause(s)	and manner as place, and due	stated. to the cause(s)
To the rethin omple	₹ S	29b. Signature and t	title of certifier	4				29c. Licens	e number	,- ,-,	n = 12	9d. Date	signed (Month	, Day, Year)
,- > F 0		121	15 al	AD	~ .	M	. 1	DO	0	> //	859	//	1010	7
		30. Name and addre	ss of person who	completed cau	ise of de	ath (Item 23a)	Type, P	Print)				1/	1	/
		1 /	J. SMOLOS				• •		, EA	STON,	MD 216	01		

DHMH 17 Rev 1/2001

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of M Registrar Amend #7 per FH/PHYS	01-10-20	partment of H	lealth and N Bapper Fi	dental Hygie I/PHYS 01-	ene -10-2007 C	NM) 1971
	Physicia		Decedent's Name (First, Middle, Last)     RUTH DENING	RUDD			2. Date of Death Month January	Day Year 7, 2007	3. Time of Death 6:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
		d	5990 Grove Hill Road		Frede			Frederi	ck
	Funeral Director		117-26-0577 1□M 2\XF	ge (In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth Decent, Day IV	94929 9. Birth Cou 1928 New	place (State or Foreign Intry) York
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	Mary a-f eh	ţò	Maryland Frederick	Frederi	ck				1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	•
	death with the Maryland ime 23a or 28a-f ehow rmust be notified at	Funeral	5990 Grove Hill Road  11. Marital Status 12. Was Decedent	Ever in U.S.	2170		ecify Yes or No-	U.S.A	
35	4 within 72 hours after death with the Marylan riban "naturel", or iteme 23a or 28a-1 ehow the Wadisal Enaminer must be notified at	by Fun	Armed Forces?  1 Never Married Married 1 Never Married 2 Married 1 Yes 2 Married 3 Widowed 4 Divorced Year or Dates:	No	<ol> <li>Was Decedent of H   If Yes, specify Cuba</li> <li>Yes 2 No</li> </ol>	Specify:	Rican, etc.)	Black, White	, etc.
۲ ک	72 hou		15. Decedent's Education (Specify only highest grade completed)	16a. D	Decedent's Usual Occup	ation during most of work	ina 16	b. Kind of Business/Ir	
9500-61212	within sene.	Completed	Elementary/Secondary (0-12) College (1-4or	5+)	Give kind of work done of ite. DO NOT use retired		,,,,,	0 11	
Z D	be filed v ital Hygie id other t	ပ္ပ	17. Father's Name (First, Middle, Last)		Homemaker		e (First, Middle, Ma	Own Hon	ne
<u>a</u>	ed at b	To Be	Lyston Dening			Mildred	Moore		
Mary	d 2 should th and Men 7 ie marke treumetic		19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street	and Number or Rur	al Route Number, C	City or Town, State, Zi	p Code)
_	s 1 end 3 if Health item 27 other tr		Cynthia Regner / Daughter		O Grove Hil				
Baltimore,	Pege nent o ant: if ary or		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	Disposition (Name of crematory or other place burg Cremat	(e)	107	c.Location - City or T mithsburg,	
Rail	permit. Departr Importa eny inju		21. Signature of Buneral Service Ucensee		ROBERT E.	DATLEY & MARKET S	SON FUNE	RAL HOMES, ERICK, MD	P.A. 21701
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do not ine.	t enter the mode of dyin				Approximate Interval Between
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)  a.   Due to (or as	a consequence of)	of the	- ranc	reas		Conset and Death'S
	Examiner	_	Sequentially list conditions, b.						
	Ja Ja Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of)	):				
Ď,	e exec	Еха	resulting in death) Last Due to (or as	a consequence of)	;				
P8/P0	ificate be executed g physician and as the burial-transit	edical	d						
ROX	attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 ② No	2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv	rery Day Year
j j	at the c by the	hys	9 □Unknown						
cords, I	n requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death b	oul not resulting in the	he underlying cause give	en in Part I.	23e. Did tobac	2 No 3 Pro	the cause of death? bably 4 Unknown
Heco	sician: The law re certificate has be- irector, page 2 sho	Completed					24a. Was an autopsy performe	dy death?	opsy findings available ompletion of cause of
VITa	ian: rtifica ctor, p	BeC	25. Was case referred to medicat			26. Place of Deat	1 Yes 2 Land 1 (Check only one)	ZNO TILITES	20 140
> 5	hysic this ce	ပ္	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpati		atient 3 DOA Other	4 U Nursing Ho		ce 6 □Other (Speci	fy)
	ending Path. or: After I	atlon:	27. Manfer of Death  1	ury 28b. Tin ay Yea <i>r)</i> fnju	ury Worl	y al k? Yes 2 □No	28d. Describe how	injury occurred	
DIVISION	s after de si Directo ed in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of In building, et	jury - At home, farm tc. (Specify)	n, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	To the Hospital or Attending Physician: Within 24 hours after death. To the Funerel Director Atter this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/	death occurred at the tin or investigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)
ı	To the Within To the comp	×	29b. Signature and little of certifier		29c. Licenso	e number	mD) 29d	Date signed Month	Day, Year)
	7		30. Name and address of person who completed cause of	death (Item 23a) (T	ype, Print)				,
	V		Timothy Hickey, MD 1564 Or	possumtow	n Pike, Fre	derick,	Maryland	21701	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Segisti	rar's Signature		-	-		

			State of Maryland / Department of Health and Me  Certificate of Death			01972
		-	1 logistia.	. Date of Death	. No.	3. Time of Death
	Physici	an		Month	Day Year	M
	/Medic		Ralph Randolph Ross, Jr. Ja  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	an. 8, 2	007 4c. County of Death	6:18 P "
	Examin	er				*
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) II Under 1 Year II Under 24 Hrs. 8	Date of Birth (Month, Day, Y	Worcester 9. Birthp	lace (State or Foreign
	Director		Months Davs Mours Min.	anuary 3	,1936 Virg	inia
	<u>و</u> - ا		Usual Residence of Decedent			
	ith the Marylar or 28a-f ehow	ř	10a. State 10b. County 10c. City, Town or Location			0d. Inside City Limits 1 □ Yes 2 □ No
	8a-1	octo	Maryland Worcester Girdletree		077	Λ
	vith th	Dire	10e. Street and Number 10f. Zip Code	"	. Citizen of What Cour	ntry?
	8 23e	ral	2640 Snow Hill Rd. 21829  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific		S.A.	an Indian
	it en de	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ric	can, etc.)	Black, White,	
36	irs aff	by F	3 ☐ Widowed 4 ☐ Divorced   1 ☐ Yes 3☐ No Specify:		SpecifyWhit	е
55	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f ehow he Madical Examiner must be notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	16	6b. Kind of Business/In	dustry
52	hin 7	ple	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)	'		
55	gien er th	Completed	6 Night Watchman		umber Comp	any
Q E	d oth	Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name (I		iden Sumame)	
₹ ×	Ment Ment Merken Merken	ို	Ralph Randolph Ross, Sr. Celeste Jo			
Maryland	2 sh and ie m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Fig. 19b. Mailing Address)	Route Number, C	City or Town, State, Zip	Code)
نه ک	tand teelth im 27		Celeste Kounnas (Mother) 3512 Spring Mill Rd. Bo 20a. Method of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Date of Disposition (Name of Date of Date of Disposition (Name of Dat	othwyn,	PA 19061 c. Location - City or To	wn State
م ام	in it of the or of or of		1 Rurial 2 DC remation 3 Removal from State cometery, crematory or other place)		,	
성靠	thent rient		4 Donation 5 Other (Specify)  Cape Henlopen Crematory 1/11  21. Sign of June 1 Tryice Licensee	/0/ Fra	ankford, De	elaware
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Heelth and Mentel Hygiene Importent: If Item 27 is marked other then "natural", or Items 23s or 28s-f ehow any injury or other treumatic event, the Madical Examinar must be notified at once.		Burbage Funeral Home		• Federal	
ì	_		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r shock, or heart failure. List only one cause on each line.	SHOW		21863 Approximate
		ā				Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. ATRIAL FIGRILLATION  Due to (or as a consequence of):			
	Examiner		CORPAIADY ATTEROSCIEDOSI	5		
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	xecuted and Il-transi	Examiner	Cause (Disease or Injury that initiated events c.			
760,	ite be executed sysicien and ne burial-transit	Ě	Due to (or as a consequence of):			
	0 × 0	dicai	d.			
9 × 6	ding ise as	/We	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	any
Bo	eath etten for u	cian	in the past 12 months?    A   Property of time of death   5   Other (operity)		Month	Day Year
o.	the d y the	ysi	1 Yes 2 No 9 Unknown			
٥	that	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to ti	ne cause of death?
rds	quire on sig uld bi			1 ☐ Yes	2 no 3 Prob	eably 4 Unknown
ဝ	s bee	Be Completed		24a. Was an	24b. Were auto	psy findings available
Re	The la	E		autopsy performe	prior to co death? ■No 1 □ Yes	psy findings available mpletion of cause of
ital	en: '	e C	25. Was case referred to medical 26. Place of Death (		12.103	2010
<b>^</b>	lysici	ToE	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home	5 Aesiden	ce 6 Other (Specif	y)
0	ng Pt Iter th	ü		d. Describe how		
<u>0</u>	endir eath. or: A	atic	2 Accident investigation M 1 Yes 2 No			
Division of Vital Records, P.O. Box 68	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)	<ol> <li>Location (Streetly or Town,</li> </ol>	et and Number or Rura State)	I Route Number.
	pitei ours e eral [		29a. Certifier 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	ed due to the gave	sp(a) and manner on a	totad
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours efter death. within 24 hours efter death. completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	e and place, and due to	the cause(s)
_	To the To the Complex complex	₩ E	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Month,	
			D0062172		1/9/200	
_	c A +1	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	A .	12810
	SAH		SHARAD R SATYAL, MD 1604 MARKET ST.	rucomo	KE YTY M	0 21031
	Sta Regist		31. Date liled (Month, Day, Year)  JAN 1 1 2007  32. Degistrar's Signature			
U.			OTHER ACTION			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 10:55 a.™. LeMer1e January 16, 2007 Eugene /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner California
If I Inder 1 Year | If Under 24 Hrs. 24065 Mill Cove Road St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Yrs. Director 216-30-5638 07/24/1935 Washington, DC Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes 2 XNo Directo Maryland St. Mary's California 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or 24065 Mill Cove Road 20619 "natural", or Items 23a United States Pages 1 and 2 should be filed within 72 hours after death went of Heatth and Mental Hygiene.
ant; If item 27 is marked other than "natural", or Items 23sury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Building Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Henry Riggs, Jr. ဥ Eugenie LeMerle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Jane Riggs/Wife 24065 Mill Cove Road, California, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre:01/18/2007 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metantaho disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 2 this I Director; After this d in by the funeral d 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) D62288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Notch Rd 24035 nree NIKhi (ppal 31. Date filed (Month, Day, Year) L. Registrar's Signature JAN 1 Registrar

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of H rtificate of L			ene200	01974
Physic		1. Decedent's Name (First, Midd WILLIAM C. ST					2. Date of Death Month JANUARY	_	3. Time of Death 307 3:13AM M
/Medi Examii		4a. Facility Name (If not institution TALBOT HOSP	_	or)	4b. City, Town, or	Location of Death	1	4c. County of	Death
Funeral Director		5. Social Security Number <b>070–20–6720</b>	6. Sex 7. A	Age (In yrs. last birthday, <b>79</b> Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, APR 20	Year)	9. Birthplace (State or Foreign Country)  NEW YORK
Aaryland Febow	or	Usual Residence of Decedent  10a. State 10b. Count  MD T	ALBOT	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 XNo
with the A a or 28a-	Director	10e. Street and Number 26338 ARCADI	A CHOPRE I AI	NT?	10f. Zip Code	1601	10	g. Citizen of Wh	nat Country?
ire, INALY IAILY ZIZIO-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 ie marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Deceder Armed Force 1 X Yes 2 If Yes. Give	nt Ever in U.S. 13. s? ] No	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Black,	American Indian, White, etc.
Maryiarid Z I Z I 3-UU30 ud 2 should be filed within 72 hours at th and Mental Hygiene. 27 ie marked other than "natural", or traumatic event, the Medical Exam.	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-40	(Give	edent's Usual Occupa e kind of work done of DO NOT use retired	during most of wor	king	<del></del>	CTURING
arytand  should be fill and Mental H le marked oth aumatic even	To Be	17. Father's Name (First, Middle WILLIAM H. ST  19a. Informant's Name/Relation	OREY	10b Mail	ing Address (Street	LILL	IAN A. SM	YTH	
00		JO ANN STOREY  20a. Method of Disposition  1X Burial 2 Cremation  4 Donation 5 Other (	/WIFE 3 □Removal from Sta	26. Place of Disp cemetery, cre	338 ARCAD	IA SHORE:	S LANE, E	ASTON, I	MARYLAND 21601 ity or Town, State  LE, NEW YORK
permit. Pag permit. Pag Depertment Important: I any injury o		21. Signature of Fur eral Service		1 2	2. Name and Addres	ss of Facility	IN & NEWN	AM FUNE	RAL HOME PA
Physician /Medical		23a. Part 1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	aa	sed the death. Do not en	290 S. ĤA Iter the mode of dyin	g, such as cardiad	or respiratory arre	st,	Approximate Interval Between
sate be executed x3 whysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>1</b> c	as a consequence of):					
The Colds, 7.0. BOX 00/ The law requires that the death certificate ate hes been signed by the ettending physpage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Monti	,
quires that	by	Part II. Other significant condit	tions contributing to death	but not resulting in the the	underlying cause give	en in Part I.			ute to the cause of death?
OI VIKAI NECOLO Physician: The law requir r this certilicate hes been si ral director, page 2 should	Completed	25. Was case referred to medic						ed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 \( \sum \) No
Affer Affer and a series	ation: To Be	examiner? 1 Yes 2 No 27. Manney of Death 1 Natural 5 Pend 2 Accident inves	Hospital: 1 ☐ Inpa  28a. Date of Ir (Month, I	atient 2 ER/Outpatie	of 28c. Injury Work	er: 4 🗆 Nursing H	ath (Check only one one 5 Resider 28d. Describe hor	nce 6X1Other	
LIVISION Attentions at the Director:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 286. Place of	Injury - At home, farm, si etc. <i>(Specify)</i>	treet, factory, office		28f. Location (Str City or Town,	eet and Number State)	or Rural Route Number,
To the Hospital within 24 hours a To the Funeral i	edical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the be il Examiner: On the basis and manner	s of examination and/or is	th occurred at the tim nvestigation, in my of	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manr te and place, an	ner as stated. Id due to the cause(s)
To the within 2 To the complet	M	29b. Signature and title of certification (Control of Certification)	llest		29c. License			-	(Month, Day, Year)
201104			A Schille	Adeath (Item 23a) (Type	Print) Cque	vood Pr	East	on me	21601
St Regist	ate	31. Date filed (Month Day, Yea	4 2007 32.	strar's Signature	6.0				

		ļ.	For State Registrar	State of Maryland /		ment of He icate of D		Mental Hy	gienę Reg. Nd	211117	01975
ı	Physici /Medi	_	1. Decedent's Name (First, Middle, Last)  Lavant John	Stambro				2. Date of D Month	Day	13 200	3. Time of Death 7 835 AM
	Examir	+	4a. Facility Name (If not institution, give	treet and number)	41	o. City, Town, or I	STO N		19	County of Dear	th
	Funeral Director		122 30 1212	7. Age (In yrs. last) 58		Under 1 Year onths Days	If Under 24 Hrs Hours Min		rth ay, Year) 2, 194	9. Birn	thplace (State or Foreign buntry) Jersey
	with the Maryland s or 28e-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Carolin		own or Locati				<u>.</u>		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28e-	I Director	10e. Street and Number 5750 Jester Road			10f. Zip Code 21632			10g. Citi	zen of What Co	puntry?
920	72 hours after death with the Maryland natural; or items 23s or 28e-f show disal Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	I2. Was Decedent Ever in U.S. Armed Forces? 1	If Ye	Decedent of His s, specify Cuban Yes 2 No	panic Origin? (s , Mexican, Puer Specity:	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, Whit	e, etc.
Baltimore, Maryland 21215-0036	d within giene. ir then	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			's Usual Occupat d of work done du NOT use retired) al. Drive		rking		nd of Business Lic Trar	Industry rsportation
yland ;	d air	To Be C	17. Father's Name (First, Middle, Last)  John A. S	tambro			Emily L.		wers		
, Mar	nd 2 salth ar 27 is		19a. Informant's Name/Relationship (Ty Lavant Stambro / s	on	415 Kerr	ddress (Street ar . Avenue, A	pt. A, De				Zip Code)
imore	Pages nent of int: if it iry or o		20a. Method of Disposition 1 ☐ Burial 2Д Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	BITIOVAL HOLLI STATE	of Disposition tery, cremato talCrem	n (Name of any or other place, extory	1/14	Date 4/2007	20c. Lo	cation - City or	Town, State
Balt	permit. Departm Imports any inju		21. Signature of Funeral Service License	! hour	Moor		Home, PA,			it., Dento	n <b>,</b> MD 21629
4	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  Myo curd to		ne mode of dying,	such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
0 -	/Medical Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence Due to (or as a consequence	and	rennggh.	Hey				years
68760,	icate be executed physician and s the burial-transi	edical Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to ras a Sequence	den 05:3, 9	disesse invalig	ed				years
.O. Box	ne death certil the attending thed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		opic pregnancy ner (specify)			2	23d. Date of del Month	ivery Day Year
Δ.	w requires that the back of th	۾	Part II. Other significant conditions cor	tributing to death but not resulting	in the under	lying cause giver	in Part I.				the cause of death?
of Vital Records,	. 44 0	Completed						24a. Was auto perfi 1 \subseteq Yes		prior to death?	topsy findings available completion of cause of
Vita	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient ➤ ER/C	Outpatient 3	DOA Other		ath Check only			
	fte fine	atlon; T	27. Manner of Death  1- Natural 5 Pending 2 Accident Investigation		. Time of Injury	28c. Injury a Work?	4   I lang L	fome 5 Res 28d. Describe			cify)
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completaly filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street,	factory, office		28f. Location ( City or To	Street and wn, State)	d Number or Ru	iral Route Number,
	in 24 hour	edical	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my knowled er: On the basis of examination a and manner stated.	ge, death occ and/or investi	curred at the time gation, in my opin	, date and place nion, death occu	a, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To To Com	Σ	29b. Signature and title of certifier	harry, Mis		29c. License		33	29d. Date	isigned (Month	n, Day, Year)
			30. Name and address of person who co	Tiple cause of death (Item 23)	(Type, Prin	15 / AME	, Eas	33 ton, 1	(D) Z	21601	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	14.8	A. A	,				

STAMBED, LAVART SCAN

07-00155 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Scott Dean Stieve State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Scott Dean Stieve Medical Examiner 1120 hrs January 6, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Min Foreign Michigan Days Hours Director 215-04-5012 1X M 2 Yrs March 2, 1967 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show Yes 2 X No Silver Spring once. Maryland Montgomery imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nenr of Health and Mental Hygiene
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10e. Street and Numbe or items 23a or 28a-must be notified at 10f. Zip Code 10g Citizen of What Country ö 13900 North Gate Lane 20906 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 1 X Sever Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No Widowed Divorced If Yes, Give Year 1 Yes 2 No specify: White Specify traumatic event, the Medical Examiner Š or Dates 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 2 Mechanic Automobile 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Dennis Stieve Be Barbara Jean Gehringer 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jean Kientz/ Mother 13900 North Gate Lane, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date Baltimore, permit Pages I
Department of H
Important: If it crematory or other place) 1 & Burial 2 Cremation 3 11, Jan. Gate of Heaven Cemete 2007 Silver Spring, Maryland Donation 5 Other Specify 21. at le of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc Nehard I Meleo 500 University Blvd, W., Silver Spring, MD 2090 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and Death a Acute Myocardial Infarct Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) b. Thrombosis right coronary artery Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause Atherosclerotic Cardiovascular Disease (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit Physician/Medical UNPENDED attending physician or use as the burial **AMENDED** Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? signed b þ Yes 2 No 3 Probably 4 Completed certificate has been 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 1 V Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient this 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other ۵ 1 V Yes 28a Date of Injury (Month, Day Year Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 V Natural Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Homicide

To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After

State

Registrar

29a Certifier 1

29b Signature and title of certifier

Ana Rubio MD

31. Date filed (Months Day

and manner stated

Assistant Medical Examiner

egistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

T 2007

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 7, 2007

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#7,8 &17 per FH, G864,2720,07, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Judith Jan. 5, 2007 Smith 1230 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's 7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 1938 9. Birthplace (State or Foreign Country) 1□M 2**X**F 75 68 Yrs. 311-38-0473 11/12/<del>1931</del> Indiana Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits MD Prince George' Laurel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7700 Cherry Lane 20707 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher 12 Education 17 Father's Name (First, Middle, Last)
Lucius Smith
Lucius Smith 18. Mother's Name (First, Middle, Maiden Sumame) Anne V.Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 0126 Mary Lucas/Niece 383 Saddlewood Circle, Highland Ranch, CO. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☑Removal from State Holy Cross Cem 1/11/07 Indianapolis, Indiana 4 ☐ Donation 5 ☐ Other (Specify) ral Service License e 21. Signature of F PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Staphylococcal bacteremia Due to (or as a consequence of): Renal failure Sequentially list conditions, if any, leading to infrindiate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 TInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

physicien and s the burial-transit The law requires that the death certificate be executed P.O. Box 68760. esn ŏ ned by the a detached f Division of Vital Records, been signed should be d page 2 certificate or Attending Physician: director this After thi To the Hospital or Attending
within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

**Physician** 

/Medical

Examiner

Director

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Medical Certification:

**Funeral** 

Director

17 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Mudical Examinar must be notified at

72 hours after

12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r

pormit. Pages 1 and 2.
Department of Health an important: If item 27 is many injury or other:

**Physician** 

Examiner

/Medical

3altimore, Maryland 21215-0036

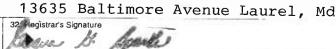
Darryl Hill MD State Registrar

31. Date filed (Month, Day, Year) JAN 10

o completed cau

29b. Signature and title of certifier

30. Name and address of person



of death (Item 23a) (Type, Print)

29c. License number

0053235

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 20 AM 01 eward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. If Under 1 Year Cchap Somer Scot 8. Date of Birth (Month, Day, 8-27-5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) 215-38-0618 Months 1 ☐ M 2 🔭 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "neture!; or iteme 23a or 28p.º \* hours injury or other traumatic event, the Menteure E. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director 055 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 218 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2DNo Yes, Give 1 ☐ Yes 2 No Specify Specify: Black Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NO-Ke House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be conder ဥ Marias 101210N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) trec 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Benvio Smith P. O. BOX 331 loconeico 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** O. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the deeth certificate be executed ettending physician and for use as the burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I., 23e. Did tobacco use contribute to the cause of death? þ cete hes been sig , page 2 should b 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 No 70 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (tjem 23a) (Type, Print)

29b. Signature and title of certifier

1604-



29c. License number

554422

(VI)

2185

29d. Date signed (Month, Day, Year)

2007

			1 - For State Registrar	State of Mary		artment of F			giene	01980
			1. Decedent's Name (First, Middle, Last	)	1			2. Date of De	aath	3. Time of Death
	Physici /Medio		WILLIAM EDWARD	THOMAS ,SR				Month O 1	Day Yea 7007	4.4
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	· · ·	4c. County of De	1 2 3 3 4
			Corsica Hill Nurs	sing Center		Centr	eville		Queen A	nnec
	Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		irthplace (State or Foreign Country)
	Director		1/4-36-9189	<b>7</b> M 2□F 57	7 Yrs.	Months Days	HOUIS MIII.	06-13-	1010	yland
	pue *		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				
	l sho	ō								10d. Inside City Limits 1 □ Yes 2 □ No
	the N	Director	Maryland Queens Ar	ine	Centrevi	11e 10f. Zip Code			10g. Citizen of What (	
	with a or	₫				Toi. Zip Code				Country !
	ns 23	Funeral	205 Armstrong Av	re. 12. Was Decedent Ever	in U.S. 13. V	2161 Was Decedent of H	*	necity Yes or No	USA	nerican Indian.
(C	riter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No		f Yes, specify Cuba	an, Mexican, Puerto	o Rican, etc.)	Black, Wh	
8	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify:	Black
က်	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	tent's Usual Occup	ation	kina	16b. Kind of Busines	
7	ithin Ban	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	Killy		
7	filed within 72 hours after death with the Maryland Hygiene. ther than Inatural', or Items 23a or 28a-f show ant, the Markeal Examinar must be mailfied at		12		Ref	inery te			Sun Oil R	efinery
Maryland 21215-0036	he fi	Be	17. Father's Name (First, Middle, Last)	0				ne (First, Middle,	, Maiden Surname)	
3	should ind Men s marke umatic	<sup>2</sup>	William Edward				Alice	Thom		
Mai	C1 .0 = e2	0.3	19a. Informant's Name/Relationship (Ty	, , , , , , , , , , , , , , , , , , , ,					er, City or Town, State,	Zip Code)
	1 and Health em 27 ther tr		Tammy Cox Cottman 20a. Method of Disposition	/ Daughter	Db. Place of Dispo	Morton Av	ze.,Chest	er, Pa.	19013 20c. Location - City of	r Tourn State
Ď	Pages nent of I nnt: if it		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ F	ioniovan nomi State		sition (Name of natory or other place	1		, and the second second	
Baltimore,	it. Purtme		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>			Crematory	7   01-1	5-2007	Dover, De	laware
Ba	permit. Page Department ( Important: If any injury or once.		21. Signature of Fulleral Service Licens	-		Bennie Si	ith Fune	ral Hom	e Maryland 2	1601
			23a. Part1. Enter the disease or some	cations that caused the						Approximate
L	Ol		23a. Part1. Enter the disease of complishock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	20		9, 02011 40 0210100	or roopiratory at	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Lun	g Cane	z				<6months
	Examiner			Due to (or as a con	g tuerice or):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	sequence of):					
	d d ansit	Examiner	that initiated events							
o	an an rial-tr	Exa	resulting in death) Last	Due to (or as a cor	sequence of):					
8760	The law requires that the death certificate be executed its has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal		l						
39	ng pt ng pt a as t	0	IF FEMALE:	_		-				
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1□Live birth 2□I		Ectopic pregnancy			23d. Date of de	,
0	the a	/sic	1 Yes 2 No	4□Pregnant at time 9□Unknown	of death 5 □	Other (specify)			Month	Day Year
<u>.</u>	w requires that the de been signed by the should be detached	by Physiclan/M	Part II. Other significant conditions con	tributing to death but not	resulting in the un	dorhina cauco dive	o in Part I	220 Did to	obacco use contribute t	to the equal of death?
Records,	signe d be	l by	Pouph		cular	Discas		1 10	_	robably 4 Unknown
ö	y requ	ete	•	VCV I	and t	PISCW				
ě	has has	Completed	HTW					24a. Was autop	sy prior to	utopsy findings available completion of cause of
			05.34					1 Yes	2 No 1 □ Ye	s 2 No
Vital	sician: certific rector,	o Be	25. Was case referred to medical examiner?	ospital:	0 C 5000	Othe	26. Place of Dent			
0	Phys rthis raldi	$\vdash$	1 Yes 2 No	1 ☐ Inpatient  28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 DOA	4 Jursing Ho		dence 6 Other (Spenow injury occurred	ecify)
o	th. : After	tlor	1 Detural 5 Pending 2 Accident investigation	(Month, Day Yea	r) Injury	28c. Injury Work M 1 1	? ∕es 2 ⊡No		iow injury coodinou	
DIVISION	Attendi r death. sctor: A by the fu	lfica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	At home, farm, stre	eet, factory, office		28f. Location (S	Street and Number or F	tural Route Number,
ב	alor s afte ni Dir	Certification;	4  Homicide	building, etc. (Sp	ecity)			City or Tow	m, State)	
	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director,		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge, death	occurred at the tim	e, date and place,	and due to the o	cause(s) and manner a	s stated.
	he H in 24 he Fu plete	Medical	(Check only 2 Medical Examir one)	ner: On the basis of exam and manner stated.	nination and/or inv	estigation, in my op	oinion, death occur	red at the time, o	date and place, and du	e to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier	_		29c. License		2	29d. Date signed (Mon	th, Day, Year)
			R. F. Dinas	MD		D006	1688		01/10	107
			30. Name and address of person who co		_	-				
			Repal Desai			Deive	Uhester	MD	21619	
	Star Registra		JAN 12 20	07 32. Rigistrar's Si	A A					

5000			For State Registrar	State of Marylar		rtment of H		Mental Hy	giene Reg. No.	2007	01981
	Physic	an	1. Decedent's Name (First, Middle, Last,	-		10		2. Date of De Month	eath Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give COASTAL HOSPICE	1 1 1 1.		4b. City, Town, or	r Location of Deat			County of Death	
166	Funeral Director		5. Social Security Number 6. Se		last birthday)_ Yrs.	Months Days	If Under 24 Hrs Hours Min.		ay, Year)		place (State or Foreign ntry) yland
	iryland ihow fat	_	10a. State 10b. County	10c. Cit	ty, Town or Loc	ation					10d. Inside City Limits
	the Ma 28a-f s notified	Director	MD Somerse  10e. Street and Number	t Pr	incess	Anne 10f. Zip Code		1	10a. Citiz	zen <i>o</i> f What Cou	1 ☐ Yes 2[X] No
	th with 23a or ist be	al Di	12105 East Ridge	Road			1853		-3 -	USA	,
920	u within 72 hours after death with the Maryland jiene. Jene. r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	by Funeral I	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		as Decedent of H Yes, specify Cuba □ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - Ameri Black, White, Specify:	
2-0	72 hou matura	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decede	ent's Usual Occup	eation during most of wo	rking	16b. Kir	nd of Business/Ir	
21215-0036	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	owr		d) -		Elec	ctronics	Store
	it be	Be C	17. Father's Name (First, Middle, Last)	none			18. Mother's Nar	me (First, Middle			beore
Maryland	should be and Mental smarked o	2	Irving J. Townsen  19a. Informant's Name/Relationship (Ty		19h Mailing	Address (Street	May L. and Number or R.	-	nar City o	Town State 7	n Code)
Ma	d 2 th a 17 is trau		Lola V. Smith/Sis		T		Lane, Se		-		o Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition  ■ Burial 2 □ Cremation 3 □ F	20b. Femoval from State	Place of Dispos cemetery, crem	ition (Name of atory or other plac	ce)	Date	20c. Lo	cation - City or T	own, State
Iţim	artmen artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify)	Wa			ery 01/1		Shac	Point,	Maryland
Ba	Depart any i		Anest June	M00295			ss of Facility neral Hor erset Ave		0000	Anno	MD 21853
y	the dist		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o		th. Do not ente	r the mode of dyir	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	JAMA CO	MUNDO	BFICIB,	NY D	15R1	45 B	Ondoi and Boati
	Examiner		Sequentially list conditions	ANRMI	A		_				
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	1.00					
oʻ	execu an and rial-tra		that initiated events resulting in death) Last	Due to (or as a conseq		7 3					
8760,	icate be executed physician and s the burial-transit	dical		d			_				
O. Box 6	ath certifi attending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \triangle	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3□	Ectopic pregnancy Other (specify)	1		2	3d. Date of deliv	ery Day Year
Δ.	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions co	ntributing to death but not res	ulting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ords	n require been sig should b							1 🗆	Yes 2	No 3□ Pro	bably 4 ∐Unknown
Il Records,		Completed						24a. Was auto perfi 1∐ Yes		24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
Vital	Physician: Tr r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ 40	Hospital: 1	ER/Outpatient	3 DOA Oth	or.	ath (Check only		Пош /	
ò	ding Phys h. After this funeral di	1 m	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur	4 Li Nursing r	Home 5 ☐ Res 28d. Describe			fy)
Division	at at	Certification:	2 Accident 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h	ome, farm, stre	M 1 🗆	Yes 2 □ No		(Street and		al Route Number,
۵	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical Cer	29a. Certifier (Check only one)  Certifying Phy Certifying Phy Certifying Phy	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the tire estigation, in my o	me, date and plac	e, and due to the	e cause(s)	and manner as	stated. to the cause(s)
	To the within 3	Mec	29b. Signature and title of certifier	and mariner stated.		29c. Licens	e number		29d. Date	e signed (Month,	Day, Year)
			1860	1/2		Doos	58410		/	1-10-	07
			30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type, F	rint)	( =	CAZIC	ni.	RU II	07 P2180/
	Sta		31. Date filed (Month, Day, Year)	32. Regular s Signa	ature		<u> </u>	3/1013	1041	7	- 21001
Division	Regist		JAN 1 2 2	2007 Jeen	# 1	how				·	
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			1 - For State Registrar	State of M			nt of H	lealth a		lental Hy		007	01982
	Physic	ian	Decedent's Name (First, Middle, La	*	K II M D O W	or				2. Date of Dea		Year	3. Time of Death
	/Medi	cal	Pear		rumpow					JAN.		2007	1:35A M
1	Examir	ner	4a. Facility Name (If not institution, gi 6719 Eldorado		)			Location of a 1 s b t				unty of Death	ter
	Funeral	г			ge (In yrs. last bi	irthday) If Und	ler 1 Year	If Under:	24 Hrs.	8. Date of Birt	h		place (State or Foreign
	Director		227 34 1042	1□M ¾CXF	88	Yrs. Month	s Days	Hours	Min.	Dec. 3,	1918	Virgi	inia
	and w	]	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	vn or Location						1	IOd. Inside City Limits
	Mary I sh	ţ	Maryland Dorches	ter	Fe	deralsb	urg					:	1 □Yes 2√□No
	or 28g	lrec	10e. Street and Number			10f. 2	Zip Code				10g. Citizen	of What Cour	ntry?
	23a c	ralD	6719 Eldorado	Road			21	632		Ţ	Jnite	d Sta	tes
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Exami wr must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		edent of Hoecify Cuba 2/DXNo	ispanic Orio in, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	1	Race - Americ Black, White, ecify: W	
5-0	72 hc	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a	Decedent's Us	sual Occupa	ation during most	t of worki	na l	16b. Kind o	of Business/In	dustry
7	within sne.	dm	Elementary/Secondary (0-12)	College (1-4or	5+) H	(Give kind of Ville. DO NOT		()			Own	Home	
d 2	filed Hygir ther int,	ပိ	17. Father's Name (First, Middle, Las	")	111	Omemak	<u> </u>	18. Mothe	r's Name	(First, Middle,			
<u>la</u> n	D 2 2 0	To Be	Rudolph Johnso	n				Mamr	nie	Kay Jo	ohnso	n She	rman
ary	s 1 and 2 should if Health and Men Item 27 te marke other treumatic		19a. Informant's Name/Relationship			. Mailing Addre							
<b>≥</b>	1 and 1 Health Iam 27		Barbara Wesley	/ Daughte									D 21632
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1 反 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Service Lice	fy)		of Disposition (A lary, crematory of aven Mer	m. Pa	rk 0	1/17		Glen H	· ·	Maryland
Ba	permit. Depertrimports any injure.		In his true	n. CMI						iptom Fu leralsbu			
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause	d the death. Do							D 2105.	Approximate
	Physician		Immediate Cause (Final disease or condition	one cause of each i	ctac			ER					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence		1110	٧					
н	Examiner	L.	Sequentially list conditions,	b.	ra entra artendora y	440				·			
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Ö	thet the death certificate be executed ad by the attending physicien and detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic 5 □ Other (					23d.	Date of delive Month	ory Day Year
	res that igned b be deta	by Pi	Part II. Other significant conditions	contributing to death b	out not resulting i	n the underlying	cause give	n in Part I.		23e. Did 1o	bacco use c	contribute to th	ne cause of death?
ğ	w require been sig should b	edit								1 🗆 Y	es 2⊡No	o 3□ Prob	ably 4 □Unknown
Vital Records,	The law requires thet ste has been signed b page 2 should be deta	Completed								24a. Was a		lb. Were autop	psy findings available
										perfor		death? 1 ☐ Yes	
=======================================	Attending Physician: The lav r death. ector: After this certificete has by the funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only or			
ō	Phys er this eral di	7: T	1 ☐ Yes 2 ☑ No 27. Mannyr of Death	28a. Date of Inju	iry 28b.	ItpatienI 3□ □	28c. Injury Work	4 LI NUI		ne 5 Resid			1)
<u></u>	ath. r: Afte	atlo	1	( <i>Month, D</i> a	y Year)	njury M		:? /es 2 □ ħ			,		
Division of	in Signature	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of in	ury - At home, fa c. (Specify)	ırm, streel, facto	ry, office		2	8f. Location (S. City or Town	treet and Nu n, State)	imber or Rura	l Route Number,
	To the Hospitel or Attending Physiking A bounded to the Autors of the Tothe Funeral Director: After the completely filled in by the funeral:	Medical	29a. Certifier 1 Certifying PI (Check only one)	nysician: To the best niner: On the basis o and manner st	t examination an	e, death occurre d/or investigatio	d at the tim in, in my op	e, date and inion, deatl	i place, a h occurre	and due to the co	ause(s) and late and plac	manner as st	ated. the cause(s)
)	with To Corr	2	29b. Signature and title of certifier	Squires	mo	1		E100		13	1/1	gned (Month, 1 15 10 7	
	Sta	10	30. Name and address of persoh who  31. Date filed (Month, Day, Year)	Squile	leath (Item 23a)	(Type, Print)	5 1	uton	1 B	Blud., D	agsbo	pro, Di	E 19939
	Registr		, , , , , , , , , , , , , , , , , , , ,	•	3	<u>.</u>							
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			1 - For State Registrar	State of Mar		artment of H <i>rtificate of L</i>	ealth and Me D <i>eath</i>	ntal Hygie Reg.	L 0 0 1	01983
	Dhysiai		1. Decedent's Name (First, Middle, Last	")			2	Date of Death	Day Year	3. Time of Death
	Physici /Medi				aylor		J		14 2007	0330 M
	Examir	er	4a. Facility Name (If not institution, give				Location of Death	'	4c. County of Death	1
	Funeral		The Memorial Hos  5. Social Security Number 6. Se	1	In yrs. last birthday)	Easta If Under 1 Year		Date of Birth	79/b07	place (State or Foreign
в	Director		221-20-2443	□M ¾C¥F	74 Yrs.	Months Days	Hours Min. M	ay 14, 1	ar) Cou	intry) Ware
	and *		Usuaf Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Marylan febow	5	Maryland Caroline		•	eston				1 ☐ Yes 2 ☑ No
	ith the Ma or 28a-f	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	th wit	Funeral Director	4771 Newton Ro	ad			21655	Ur	nited St	ates
	ter dea	unei	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specit n, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White	can Indian, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> XNo ff Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	hite
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or itema 23s or 28s-f show other treumatic event, its Mudical Evanterment La notified at	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occupa	tion	16b	. Kind of Business/li	ndustry
21	- 3	Completed	Efementary/Secondary (0-12)	Coffege (1-4or 5+)			furing most of working			
121	iled w Hygier ther th		12 17. Father's Name (First, Middle, Last)		110	memaker	18. Mother's Name (F	Tont Adjudate Admir	Own Ho	me
and	is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other then other treumatic event, items.	To Be	Robert Lofland				Pierce A			
3	should Mind Mind Mind Mind Mind Mind Mind Min	۴	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Maili		nd Number or Rural F			o Code)
Z	and 2 salth a n 27 is		Janice T. Stanl	ey/Daught	er 2341	O Carrol	1 Rd., P	reston,	MD 216.	5.5
Baltimore,	Pages 1 nent of He ant: If iter ury or oth		20a. Method of Disposition		20b. Place of Dispo cemetery, crea	osition (Name of matory or other place	Date	20c.	Location - City or T	
Ë	t. Pag rtmenl rtant:		4 □Donation 5 □ Other (Specify)				ery 01/18/		ston, Mar	yland
Bal	permit. Pages Depertment of Important: If it eny injury or c		21. Signature of Funeral Service Licens	Eskow	21	2. Name and Address 16 N. Main	s of Facility Framp a St., Fede	tom Fune ralsburg	eral Home, g, MD 2163	P.A. 32
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused th ne cause on each line.	e death. Do not en	ter the mode of dying	g, such as cardiac or re	espiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a ASPINA	tion (	neumo	NIA			Onset and Death
1	Examiner				consequence of):		·			1/246
		Jer	Securitally list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c						YEARS
	acuted ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
68760,	icate be executed physician and s the burial-transit	al E	1650ming in death) Last	Due to (or as a c	onsequence of):					
687	ficate physis the	edical		d						
Вох	eath certif ettending for use a	W/u	23b. Was decedent pregnant	23c. If yes, outcome of a		Testopio processos			23d. Date of deliv	ery
P.O. B	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at tim 9☐ Unknown		Dectopic pregnancy Other (specify)			Month	Day Year
Œ.	s that pned b		Part II. Dther significant conditions co.		not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
ord	w requires that s been signed t s should be det	ted	cerebral is	chemia				1 🗆 Yes	2.2No 3 ☐ Pro	oabfy 4 □Unknown
ec	e 2 sh	Completed by						24a. Was an autopsy	prior to co	ppsy findings available impletion of cause of
a F	ysician: The lav is certificate has director, page 2.							performed		2 🗆 No
Κ	s certification	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	fospitaf:	2 ER/Outpatier	04-	26. Place of Death (C		a 1710 /a	
٥٥	g Physical this		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of	" 3 DOA	4 Indising Home	. Describe how in		(v)
sior	endin eath. or: Alt	atio	1 Natural 5 Pending 2 Accident investigation	(Worth, Day 1	ear) tnjury		es 2 □No			
Division of Vital Records,	al or Att safter d i Direct d in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, str Specify)	reet, factory, office	28f.	Location (Street City or Town, Sta	and Number or Rura ate)	al Route Number,
	To the Mospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or in	h occurred at the time vestigation, in my opi	e, date and place, and inion, death occurred	due to the cause at the time, date a	(s) and manner as s and place, and due to	tated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1		29c. License		29d. [	Date signed (Month,	Day, Year)
			Muhad )	June,	ND		1867	(	14/07	
			30. Name and address of person who co				Eastm 1	nd 2	1601	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Idlewi/	G AUC	EUDIN	TILD OF	1001	
7.	Registr		JAN 1 2	107 Debates	Signature	grands				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health an 1 = Registrar	d Mental I	Hygien	е	
	中	1.5	Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. N	6007	01984
	Physic		Gerald LeRoi Thompson	Month	D	ay Year	3. Time of Death
No.	/Medi Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of D			3, 2007 c. County of Death	3:20 p <sup>M</sup>
1			Holy Cross Hospital Silver Spring	a	,	Montgomery	
100	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours 1	Hrs. 8. Date of	Birth Day, Year	9 Birthola	ace (State or Foreign
ŀ	Director		Usual Residence of Decedent		-	1937 Idaho	* /
	faryland show ed at		10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
	Many a-f sh ffied	tor	Maryland Montgomery Kensington				1 ☐Yes 21 No
	with the Mary a or 28a-f she be notified a	Director	Maryland Montgomery Kensington  10e. Street and Number 10f. Zip Code		10g. C	itizen of What Countr	y?
	th wil	al	3212 McComas Avenue 20895			USA	
	items items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Pr	? (Specify Yes or	No-	14. Race - America Black, White, et	
36	s afte	by F	1 Never Married 2 Married   1 Mayes 2 No	, , , , , , , , , , , , , , , , , , , ,		SpecWhite	0.
21215-0036	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ed b	15. Decedent's Education 16a. Decedent's Usual Occupation		165	Kind of Business/Indu	
215	nin 72 In "na Medik	Completed	(Specify only highest grade completed)  (Give kind of work done during most of life. DO NOT use retired)  (Give kind of work done during most of life. DO NOT use retired)	working	100.1	And of Business/indu	stry
212	d withii giene. er than the M	E O	Chairman/CEO			ation Sys	tems
	be filed within 72 ho tral Hygiene. d other than "natul event, the Medical	Be (		Name (First, Mid			
yla	should be and Mental marked o	10	Roy Alton Thompson			ret Colvi	
Maryland	and רי is m is m raum	1 3	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number of Part In Company				ode)
	ss 1 and 2 should by Health and Ment item 27 is marked other traumatic er	1	Kathleen M. Thompson/ Wife 3212 McComas Avenue,  20a. Method of Disposition 20b. Place of Disposition (Name of	, Kensin			
nor	Pages nent of I nt: If it		1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)	n. 20,	20c. L	ocation - City or Tow	n, State
Baltimore,		1		2007	Gle	nns Ferry	, Idaho
Ba	permit. Departr Imports any Inj.	0 3	21. Signardie of Funeral Service Licersee  Francis J. Collin 500 University B1	ns Funer. Lvd, W.,	al Ho Silv	me Inc. er Spring	, MD 20901
			23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure List only one cause on each line.			4	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition			, (	Onset and Death
-	Medical Examiner		Due to (or as a consequence of):				"
**	-xaiiiiici	<b>5</b>	Sequentially list conditions, if any, leading to immediate b. Sersis  Due to (or as a consequence of):				_
	rted nsit	mine	causs. Enter Underlying				
,	execunand nandial-tra	Examiner	that inlitated events resulting in death) Last  C. Urinary Tract Infection  Due to (or as a consequence of):				
68760,	tificate be executed g physician and as the burial-transit	edical	d Pneumonia				
	rtifica ng ph as th		IF FEMALE.				
Вох	The law requires that the death cert the heas been signed by the attending age 2 should be detached for use.	Physician/M	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome pf pregnancy   1 □ Live birth   2 □ Fetal death   3 □ Ectopic pregnancy			23d. Date of delivery	
O.	the at	sici	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other (specify)   9   Unknown   9   U		-	Month D	ay Year
P.O.	hat the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	220 Di	d tobooco	una aastulkuta ta ta s	
ds,	signe d be	d by				use contribute to the	
COL	v request	Completed	Anoxic Encephalopathy	_			
Re	he lar e has age 2	dmc		— 24a. W.	as an topsy rformed?	prior to comp death?	y findings available eletion of cause of
ta		Be C	25. Was case referred to medical 26. Place of F	1□ Yes Death (Check onl			□ No
or Vital Records,	Attending Physiclan: The law r death. r death. ector: After this certificate has t by the funeral director, page 2 s	0	Hospital:			6 ☐Other (Specify)	
0	ng Pt fter th neral	ı: T	27. Manner of Death 1 № Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describ			
Sio	eath. or: A the fu	atic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
Division	or At fter d Direct in by	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or 7	(Street ar Town, State	nd Number or Rural F e)	loute Number,
	pital surs a eral [ filled		29a. Certifier DECertifying Physician: To the best of my knowledge, death occurred at the time, date and pla	0			
	e Hos 24 ho e Fun etely	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	ace, and due to the courred at the time	ne cause(s ne, date an	) and manner as stated d place, and due to the	ed. ne cause(s)
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier 29c. License number		29d. Da	te signed (Month, Da	y, Year)
	10+1		desores desores				
	10 11	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Janit	lary 8, 20	07
			Sirak Lemma, M.D. 1500 Forest Glen Road, Silver Sp.	ring, MD	2091	10	
	Sta Registra		31. Date filed (Marth, Pay, Year)  AN 10 2007  32 degistrar's Signature  Specific				
	negistr	:II	PURELLES SU PROBATES				

07-00149 Imad Umar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar State of Maryland / Department of nearth and Mental hygiene  **Certificate of Death**  **Registrar**	2007 0198
Physician/ Medical Examine	1 Decedent's Name (First, Middle,Last) Tmad Shafig Ilman 2. Date of Death	3 Time of Death
Medical Examine	Month Da January 6, 20  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death
,	12010 Woodmore Road Bowie	Prince George's
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(N DEC 11,	MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Virginia
ny .	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d Inside City Limits
nd show a	MD Durings Comments   Books	1 Yes 2 X No
th the Maryland 23a or 28a-f show any notified at once. al Director	10e. Street and Number 10f Zip Code 10g. (	Citizen of What Country?
ith the s 23a or notifie	12711 Longwater Drive 20721 Un  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	ited States
r death with or items 23 must be no Funeral	1 X Never Married 2 Married 2 Married 2 X No	14. Race - American Indian, Black, White, etc
rs after ural", o miner r	3 Wildowed 4 Divorced if Yes Give Year 1 Yes 2 X No specify or Dates:	Specify: Asian
5-0036 ed within 72 hour ed within 72 hour other than "natu the Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	b. Kind of Business/Industry
5-0036 led within 72 Hygiene other than the Medical	4 Self Employed	Retail
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f she transmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		en Surname)
D 21 Should I and Mer is man	9 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number,	
nore, MD 2 ages 1 and 2 shou nit of Health and 1 it: If item 27 is r other traumatic	Shafiq Umar / Father   12711 Longwater Drive, Bowie, 20a Method of Disposition   20b. Place of Disposition (Name of cemetery, Date 20	Maryland 20721 Oc Location - City or Town, State
F ~ ~ E E I	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Maryland Natl. Cem. 01/07/2007 Lem.	aurel, Maryland
Baltimore, permit Pages l ar Department of Hee Important: If ite	21 Signature of Funeral Servet Licensee 22 Name and Address of Facility	
Physician	M00956 Thibadeau Mortuary Service 933 Gist Av. LL, Silver Sp. 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s.	ring, MD 20910 shock, or heart   Approximate Interval
/Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease a Multiple Injuries	Between Onset and Death
- mark	or condition resulting in death)  Due to (or as a consequence of):  b.	
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
ted Insit Examiner	Unleads of hijury that initiated events resulting in death) Last Due to (or as a consequence of).	
760, icate be executed g physician and the burial - transit	UNPENDED X AMENDED TO THE FEMALE: 230 If we soutcome of prepagery	
8760, ificate be tig physici sthe buri		23d Date of delivery
Box 687 c death certifi the attending ed for use as t	past 12 months?  4 Pregnant at time of death  5 Other (Specify)	Month Day Year
P.O. Bc that the des ted by the a detached fc oy Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacc	co use contribute to the cause of death?
s, P.O. dires that the signed by Hote detacled by F.	1 Ves 2	No 3 Probably 4 Unknown
of Vital Records, ng Physician: The law require. Wher this certificate has been signeral director, page 2 should be. n: To Be Completed	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
tal Rec		
Vital I hysician: this certifi I director, To Be C	25 Was case referred to medical examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Was a No  Other Was a No  Other Was a No No No No No No No No No No No No No	idence 6 ✔ Other Scene
n of ding Ph After t funeral	27 Manner of Dooth	
Division tal or Attendius at Birector: Aled in by the furention	Pending Investigation   Same Pound   P	et and Number or Rural Route Number, City
Division o spiral or Attending rours after death neral Director: Afte filled in by the fune Certification:	Suicide 6 Could not be determined (Specify) Local Street 12010 Woodmore	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex		and manner as stated. place, and due to the cause(s)
=	and manner stated.  29b. Signature and title of certifier  29c. License number  29c. License number	d. Date signed (Month, Day, Year)
10		anuary 7, 2007
	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	THE RESERVE AND ASSESSMENT OF THE PARTY OF T	

			State of Maryland / Department of Certificate of Ce			ene 007	01986
			Registrar  1. Decedent's Name (First, Middle, Last)		. Date of Death		3. Time of Death
	Physicia /Medic		Harry Thomas Wise, Sr.		Month	Pay Year Year	09:45 AM
0	Examin		ta. Facility Name (If not institution, give street and number) . 4b. City, Tov	wn, or Location of Death		4c. County of Death	1
		<i>y</i>	Atlantic General Hospital Ber 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y		. Date of Birth		nplace (State or Foreign
	Funeral Director			avs Hours Min.	Month, Day, Y	ear) Coi	iry land
-			Usual Residence of Decedent				10d. Inside City Limits
	ehow	5	10a. State  Maryland Worcester  10b. County  10c. City, Town or Location  13ishopuille				1 Yes 2 □ No
	the N	rect	104 Zin Co	ode		. Citizen of What Co	
	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28e-1 show ha Modical Examiner most be notified at	by Funeral Director	10922 West Line Road	21813	U	nited Stat	es of America
	r deal	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 13. Was Decedent If Yes, specify	t of Hispanic Origin? (Specif Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
36	rs afte	y Fu	11. Marrial Status  1 Never Married 2 Married  1 Yes, Specify  1 Yes, 2 No  If Yes, Specify  1 Yes, Give  1 Year or Dates:	No Specify:		Specify: 13	lack
21215-0036	72 hours natural',	ted	15. Decedent's Education 16a. Decedent's Usual O	Occupation done during most of working	16	6b. Kind of Business/	ndustry
215	ithin 7 16.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	retired)	•	Doubte	u
121	fygien tygien her th	S	17. Father's Name (First, Middle, Last)	18. Mother's Name (/	First, Middle, Ma	iden Sumame)	7
anc	d be fi	o Be	Eugene Wise	Bessi	e cro	opper	
Maryland	es 1 and 2 should be filed within 7 of Health and Menta Hygiene. If Item 27 is marked other than "r or other treumatic event, Ite M.	ပ္	10h Mailine Address /C	Street and Number or Pural F	Pouto Number (	City or Town State 7	(ip Code)
	and 2 saith a n 27 is er tre			erford Ave,			
Baltimore,	f of He		20a. Method of Disposition  1	er place)		c. Location - City or	
Ë	t. Pag rtmen rtant; njury		4 Donation 5 Other (Specify)	Center Jan 17 Address of Facility Hen	Z, 2007 C	ambridge	MD
Bal	permit. Pages 1 Department of H Important; if ite any injury or ot once.		11/2000 + Marco 510 W	ashinaton St	- Cam	binduc. A	ND 21613
			23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of shock or heart failure. List only one cause on each line.	of dying, such as cardiac or r	respiratory arres	1,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Myccardial Infarc	tion			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):  Cram Negative Ro	1 Cartie	Shack		
		e	Sequentially list conditions,  Due to (or as a consequence of):		0.122		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.   Due to (or as a consequence/of):  Urinary Tract In	fection			
ó	cate be executed physician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	cate by	dical	d			-	
9		/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	ivery
2007 0. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  1 Live birth 2 Fetal death 3 Ectopic pregrim to the past 12 months?  4 Pregnant at time of death 5 Other (special parts)			Month	Day Year
2 ≥ ≥ O. P.	that the died by the detached	hys	9 Unknown		1		
5.	res the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.		cco use contribute to	obably 4 Dunknown
- 1	v requir been s should	Completed		<del></del>	24a. Was an		itopsy findings available
4 27  <sub>11</sub> 521 . الاجاراكية Wital Recor	has l ge 2 s	jdw			autopsy	prior to death?	completion of cause of
4 27  Vital	icien: The la certificate has rector, page 2		25. Was case referred to medical	26. Place of Death (	1		2□ No
	× ∞ 0	To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Othon		ce 6 □Other (Spe	cify)
jo u				Work?	ld. Describe how	injury occurred	
43 g	ten deat tor: the	cati	2 Accident investigation 3 Suicide 6 Could not be	1 Yes 2 No	It Location (Stre	et and Number or Ru	ural Route Number.
Havry 14-9316 Division	P gig c	Certification;	determined determined building, etc. (Specify)	nii ce	City or Town,		
16-	pita illed		29a. Certifier (Check only)  1 Certifying Physicien: To the best of my knowledge, death occurred at the control of the basis of examination and/or investigation, in	the time, date and place, an	d due to the cau	ise(s) and manner as	stated.
3 4	To the Hos within 24 ho To the Fun completely f	Medical	one) and manner stated.				
	T V To	2	290. Signature and title of certificity	56312		d. Date signed (Mont)	
	1 Mar		(SVE) SIGNATURE (No. 200) (Top Brief)			,	NO8,2007
	30		30. Name and address of person who completed cause of death (term 23a) (type, Pilli)  Regory W. Stannas, MD 9733	Healthway D	rive Be	erlin, mD	21811
	Sta	te	31. Date filed (Month, Day, Year) 32. Augistral's Signature				
	Registr	ar	JAN 1 0 2007 Received the Specific				

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Heelth and Mental Hygiene.
Importent: If them 27 is marked other than "naturer," or items 23a or 28a-f show
any injury or other treumatic event, the Medical Examiner must be netitived at Beeman, Mildred O.

Funer Direct

Physicia /Medic Examine

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	For State Registrar		State o	f Maryland		artment of H		ınd Mei		giene () () () () () () () () () () () () ()	7 0198		
ian ical	1. Decedent's Name (First Mildred Be	eman						1	Date of Dea Month	Day Ye	3. Time of Dec		
iner	4a. Fecility Name (If not in Lions Cente	r Nurs	ing Hom	ne		4b. City, Town, or Cumbe	rland			Ac. County of I			
	5. Social Security Number 214–12–3325 Usual Residence of Dece	10	ж ]м 2 <del>∏</del> F	7. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birt (Month, Day 11y 10	v, Year)	Birthplace (State or Fo Country) [aryland		
tor	10a. State 10b.	County 11egany			Town or Lo				10d. Insid				
Director	10e. Street and Number	) and was				10f. Zip Code				10g. Citizen of Wha			
To Be Completed by Funeral Director	901 Seton Drive  11. Marital Status  1 Never Married 2 Married 3 Midowed 4 Divorced  12. Was Decedent Armed Forces 1 Yes 2 Mill Yes 2 Mill Yes 2 Mill Yes 2 Mill Yes 2 Mill Yes 2 Mill Yes 3 Mill Yes 4 Mill Yes			rces? 2 X No e	? If Yes, specify Cuban, Mexican, Puerto			in? (Specify Puerto Rica	Yes or No- an, etc.)	American Indian, White, etc. White			
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary(Secondary (0-12) College (1-4or 5+)				(Give kind of work done during most of working life. DO NOT use retired)						ess/Industry		
To Be Co	12 17. Father's Name (First, Notley		0		hou	sewife	18. Mother	's Name (Fi	rst, Middle.	OWN hom Maiden Sumame)	meu		
-	19a. Informant's Name/R	elationship (Ty	pe, Print)		19b. Mailin	g Address (Street a	and Number	or Rural Ro	oute Numbe	r, City or Town, Sta	te, Zip Code)		
	20a. Method of Disposition	Harold Beeman/son  705 1/2 Baker Street Cumberland, MD 21502  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State											
	21. Signature of Eureral Service Licensee  21. Signature of Eureral Service Licensee  Ronald S. Wade, Director  State Anatomy Board 655 W. Baltimore Street  Baltimore, MD 21201  22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street  Baltimore, MD 21201  Approximate Interval Between Onset and Death disease or condition  Immediate Cause (Final disease or condition resulting in death)  a. Evid 5 use of Eureral Service Licensee  Baltimore, MD 21201  Approximate Interval Between Onset and Death Conset and Deat												
dical Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):												
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by	Part II. Other significant of	1 .	tributing to de		ng in the un		n in Part I.			_	e to the cause of death		
Completed	24a. Was an 24b. Were auto												
Certification; To Be	2 Accident	Pending investigation Could not be	28a. Date o (Month	f Injury p, <i>Day Year)</i>	VOutpatient Bb. Time of Injury	3 DOA Other	r: 400 Nurs	28d.	5  Reside	ence 6 Other (S			
	4 ☐ Homicide  29a. Certifier 1 🔀 C	determined ertifying Phys	ician: To the l	of Injury - At home g, etc. (Specify) best of my knowle	edge, death	occurred at the time	a date and	place and o	City or Town	n, State)	Rural Route Number,		
Medical	(Check only one)  29b. Signature and title of	edical examin	er: On the ba	sis of examination	and/or inve	estigation, in my opi	inion, death	occurred at	the time, da	ate and place, and o	due to the cause(s)		
	) wone	wk.	Hin				055	325		Javi 19	2007		
ate rar	30. Name and address of power of the control of the	SHI	N HO	or death (Item 23	sa) (Type, P	errace	Fres	thurg	НО	21532			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 10.35 PM James 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltinove Norther 1 Year | If Under 24 Hrs. Hours | Min. Secocists Haspital y Number 6. Sex 7. Age (In Birthplace (State or Foreign Country) 5. Social Security Numbe Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F 214-12-8611 Director 84 March 14,1922 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 ☑ No Directo Marvland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 455 Whitfield Road 21228 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Armed Forces: 1 XYes 2 No If Yes, Give Year or Dates:1942-45 1 ☐ Never Married 2 X Married Jo. Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ... wrental Hygiene. 127 is marked other than "! r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician 011 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Barth Rosa Coyne ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the once. Rosemary Barth Wife 455 Whitfield Road; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 1/29/2007 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Pineral Service Licenses 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Dav Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed page certificate Di 1□ Yes 2 No oea Was case referred to medical examiner? Hospital or Attending Physician: director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ NO this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in 24 hours a Medical 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) T.D.

Registrar

State

ATPAL

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

DANG

Registrar's Signature

Physic /Modi		Decedent's Name (First, M     Sonya Bella)	iddle, Last)			Indelible Ink INF #20a- partment of I 863 101 / 26/		2. Date of D Month	Death Da	ay Yea	3. Time of Death		
/Medi Exami		4a. Facility Name (If not institu		nber)		4b. City, Town, o	or Location of De			. 2007	8:25 AM		
		Casey House				Rockvil	116			ontgom			
Funeral		5. Social Security Number 110–05–2869	6. Sex 1 □ M 2 ☑ F	7. Age (In yrs.		ay) If Under 1 Year			irth		Birthplace (State or Fore Country)		
Director		Usual Residence of Decedent	1 1 W 2 X F	88_	Yrs		The state of the			918 Ne			
yland ow at		10a. State 10b. Cou	nty	10c. Cit	ty, Town or	Location					10d. Inside City Limi		
Many a-f sh ffied	żo	MD Mon	tgomery	41	Rock	ville					1 □ Yes 2√□1		
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	10e. Street and Number 1801 E. Jeff	erson Street	#607	#607 10f. Zip Code 20852		20852	10g. (		Citizen of What Country?			
items 2	iner	11. Marital Status	12. Was Deced	dent Ever in U.	.S. 1:	Was Decedent of H     If Yes, specify Cub	dispanic Origin?	(Specify Yes or N	0-	14. Race - An			
ours affer ral', or its Examine	by Fu	1 ☐ Never Married 2 ☐ N 3 ☐ Widowed 4 🔯 Divor	farried 1 ☐ Yes	2 <b>X</b> No ∍	S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl			erto Hican, etc.)		Black, Wh			
/2 nc 'natu	eted	15. Dece (Specify only hig	dent's Education phest grade completed)		16a. De	cedent's Usual Occup	ation	vorkina	16b. K	and of Busines	s/Industry		
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be riled y tal Hygie d other i event, th	a	17. Father's Name (First, Midd	, ,				18. Mother's N	ame (First, Middle			arrom		
z snould be z and Mental is marked raumatic ev	ဥ	Harold Beych			,			rine Sha					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician PEARL Month Day BOYKINS /Medical Tanvara 4a, Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Denesis Health Care Catonsville More Commons 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)

VIRGINIA Funeral 1□M 25F 219-62-5372 Director Yrs. Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be rediffed at Be Completed by Funeral Director 1 Yes 2 □ No 28a-f 10e. Street and Number 19g. Citizen of What Country? or Items 23a or 35 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 11. Marital Status . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ₩ Widowed 4 Divorced "naturat" BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: if liem 27 is marked other than "natt any injury or other traumatic event, the Medica any. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HTGRADE 4DMINISTRATIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIHORE MD. JOYCE DEGRAFFINRIED ( 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buria 2 Cremation 3 ☐ Removal from State `4 Donation 5 □ Other (Specify) CREMATORY 01-26-0 22. Name and Address of Pacility 2140 N. 21. S gnature of Funeral Service Licences 23 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final isease or condition resulting in death) Advance Piliysician YNS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Onknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? of Vital 1 Yes or Attending Physician; filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 **N**O 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? s after death. 28d. Describe how injury occurred Division 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar TURAKHIA

JAN 2 6 2007

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32 Registrar's Signature

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Dons Elizabeth E		I- For State Registrar	State	of Maryland		cate of Dea		i wentai n		g No	31) 7	0199
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Funeral Director		5. Social Security Number			e (In yrs. last bi	irthday) If Und	der 1 Year hs Days	If Under 24Hr	<b>⊣</b>	h (MM/DD/YYYY	Foreign	ce (State or
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vith the Maryland 23a or 28a-f show 2 2 notified at once.	Director	1519	ARCA	ALALE	New/	F.	p code	2121	8	//.	5 A	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland a hand Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she imatic event, the Medical Examiner must be notified at once	era	11. Marital Status		12. Was Decedent Armed Forces?		13. Was Deced	dent of Hisp	panic Origin? ( S Mexican, Puerto	pecify Yes or No-	14 Race White		Indian, Black,
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5-0036 led within 72 Hygiene other than '	dwo.	17. Father's Name (Firs	st Middle Last)			SUPE		SOR 8.Mother's Name	e (First, Middle, M	1 HRI	FI	STORE
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D 21 should I and Mei 7 is mai	ျ	19a. Informant's Name/	Relationship (Ty	6-		9b. Mailing Addres	s (Street	and Number or	Rural Route Num	ber, City or Tow	n, State, Zıp	Code)
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MOFe, Pages   ar			Cremation 3	Removal from Sta	ate crema	atory or other place	e) DATOA	01/ 1/-	14-17	BALT	WADE	MA
Baltimo permit Pag Department Important:	ŀ	4 Donation 5 21. Signature of Funera	Other Specify: al Service Licens	6	111611	22 Name an	711	SF 07	RAWA	JR. FO	INERI	AL HOME
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F 3 F 8	₩.	29b. Signature and title		and manner stated.		2	9c. License			29d. Date sign		Day, Year)
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6		30. Name Transferss Pamela E. Soi		ompleted cause of one of the completed cause of one of the complete of the complete of the cause			n Street	, Baltimore,	MD 21201			
St	ate	31. Date filed (Month, I	Day, Year)	32. Registra	r's Signature	Grantes						
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 0800 M ZURTISS BRAZI 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF MARY LUND MEDICAL CONTR BA/TIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 07/23/1961 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 278-66-9528 1 M 2 □ F OH **Director** Usual Residence of Decedent the Maryland a or 28a-f show be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD Baltimore Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 18 North Bond Street USA "natural", or items 23a edical Examiner must t death Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ones of Health and Mental Hygiene. In the Merit if item 27 is marked other than "natural", or ite any or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Black Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Schools 12 Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles C. Brazil Sr. Odevene Hunt ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 1119 Delia Avenue, Akron, OH, 44320 Stanley Brazil / Brother altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/27/2007 Northlawn Cemetery Akron, OH 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 Deulo W. Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** HYPERTENSIVE ATHOROSCIEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 3 Probably 4 □Unknown 2□ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an ate has I 2 | No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b Time of 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

S GREENE STREET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR L SKANTHARAJA
31. Date filed (Month, Day, Year)

22

32. Registrar's Signature

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			State of Maryland / Department of Health and M	ental Hygie	ene <sub>2 n n 7</sub>	01000
			Registrar Certificate of Death		J. No	リーブブン
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	Funeral			8. Date of Birth (Month, Day, Y	earl Birth	place (State or Foreign
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	ith the or 28 se not	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	ntry?
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	ter de items iner n	-une	11. Marital Status  12. Was Decedent Eyer in U.S. Armed Forces?  1	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
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altimore,	Pages 1 nent of H int; If iter iry or oth	- 6	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)	ate 20	c. Location - City or To	own, State
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Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	J.JR. Fi	in. Sve	04
	\$ \$	-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiad or shock, or heart failure. List only one cause on each line.	respiratory arrest	21213	Approximate
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uo.	in the line	ion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury Work?  2 Accident investigation  28d. Injury at Work?  1 Yes 2 No	3d. Describe how i	njury occurred	
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral Director. After this certification by the funeral director, it	Medical	one) and manner stated.			
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	<i>i</i>		30. Name and address of person who completed except of death (New 23) / 7 - 2 - 2 - 2	2 0	AN. 22,	2001
	(0)		29b. Signature and title of certifier  29c. License number  29c. License number  DO66243  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SHYED ECSHYY HD GJ S Medi C Center  31. Date filed (Month, Day, Year)  JAN 2 6 2007	D. Ro	ckville,	MD 70850
Ţ	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature			
	Registra	ar	JAN 2 6 2007 Notice 15			

			For State Registrar	State of N	Marylan		artmen ertificat				lental H	ygien Reg. N	21117		994
,	8 <sup>84</sup>		Decedent's Name (First, Middle	e, Last)							2. Date of D	eath		3. Time	of Death
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	Funeral		5. Social Security Number	6. Sex 7 1⊠M 2□F		last birthday	) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth	. 9. Bir	thplace (State	or Foreign
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<b>20</b>	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	death 3	⊒Ectopic pre					12	23d. Date of del Month	very Day	Year
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	I of the Hospital or Attending Physician: The law requires that the death certific the Puneral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		Check only 2   Medical E	Physician: To the bes examiner: On the basis	t of my know of examinat	wledge, deat	h occurred a	t the time	e, date and	d place, a	nd due to the	cause(s	s) and manner as	stated.	(e)
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	2511		30. Name and address of person v												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 17, 2007 ear 2:05 P M Marvin J. Boede January 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Months Days 1**4** M 2 □ F 78 397-22-6891 April 6, 1928 Wisconsin Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Maryland Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20854 United States 22 N. Infield Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No. If Yes, Give 46-48 Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 28 Married Specify: White 1 ☐ Yes 2K No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) International Union Goilege (1-4or 5+) Elementary/Secondary (0-12) Union Offical Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marvin Boede Leona Hensen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Madeline Boede/Wife 22 N. Infield Court, Potomac, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) January 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IC Cremation 3 ☐ Removal from State 2007 Bethesda, Maryland Montgomery Crematorium 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Avenue, Rockville, MD 20850 21. Signature of Funeral Service Licensee John P. Chapen M00092 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Hours Due to (or as a consequence of) Days Pancreatitis Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【SUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2∏No 2Ñ No 1 ☐ Yes 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

**Physician** /Medical **Examiner** 

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page 2 s certificate has

this funeral

After 1

the Funeral Director: Af

within 2

2041

Hospital or Attending 24 hours after death.

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine

Physician/Medical

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Completed

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Certification:

Medical

**Physician** 

/Medical

Director

Funeral

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Completed

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Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

27. Manner of Death 1 🛮 Natural 5 Pending investigation 2 Accident 3 ☐ Suicide

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

4 Homicide

29a. Certifier

29c. License number DO064560

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) JANUARY 24TH 2007

who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Drive, Rockville, MD 20850

IKHANT M.D. IDHI

31. Date filed (Month, Day, Year) State

32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene Registrar Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 24, 2007 DORIS **BUSHMAN** 11:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, 68-12-0904 068-12-0904 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 02/05/1922 84 NY Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐Yes 2 ☐ No Funeral Director MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 725 MT. WILSON LANE 21208 U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) traumatic event, the Medical Examiner Black White et 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Completed by 3 ¥ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Assisted Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER <del>ASSISTING</del> LIVING CENTER 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **STARK** SAMUEL HANNAH GRODEN မှ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau BRUCE\_BUSHMAN / SON 312 CHERRY HILL BLVD - CHERRY HILL, NJ. 08002 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SHALOM MEMORIAL PARK LOWER MORELAND, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congehie Physician Hear + 2 تا دىن 2 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate bace. Enter the darking Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Medical Certification: To 1 Tes 2 No 1 | Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident death within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 🛮 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D38675 25 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21202 SI BALTIMORE 301 ST PAUL SVITE 605 31. Date filed (Month, Day, Year) 32/Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JÄNÜARY 23, 2007 7:47 P M **BROOKS** SHAFA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7218 PARK HEIGHTS AVENUE BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 09/07/1907 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□ F 212-32-1106 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene important; if item 27 is marked other than "natural", or Items 23a or 28a-f show important: if item 27 is marked other than "natural", or Items 23a or 28a-f show important; if items Medical Examiner must be notified at once. 1 X Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 7218 PARK HEIGHTS AVENUE 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: If item 27 is marked other than College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( **KLINGHOFFER** SHEINDEL WILF ELIAS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1755 YORK AVENUE #3-P ARLINE BROWN / DAUGHTER NEW YORK, NY 10128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY 01/25/2007 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** minule /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Years physician and the burial-transi HAS CON Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE nse ( 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) sate has been signed by the a page 2 should be detached? 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 | Yes 2 | No 3 | Probably 4 | Jonknown dehelita 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed 1∐ Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 2 No P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ASS 13 Ked hours 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. I Director: A id in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SIH . MACINUN.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

3635 Old Court

29c. License number

1)0004701

29d. Date signed (Month. Dav. Year)

BAHinno My 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 044 AM 1071 E 2007 21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner John Baltemore yurew Km3 5. Social Security Number 6. Sex Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/22/1940 Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** CAROLINA Months Days Hours 1 □ M 2 ₩ F 217-40-7734 66 S. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.
is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at XXYes 2 □ No Director MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6219 PLANTVIEW 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNO If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: BLACK Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER DOMESTIC 12 or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fii ment of Health and Mental H ant: If Item 27 is marked ott Be WILLIE A. CLARK UNKNOWN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RANDALLSTOWN, 19a. Informant's Name/Relationship (Type. Print) MARTHA BRUNSON / DAUGHTER BARRY PAUL RD, APT 203, MD 21133 3421 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ott 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/26/07 CATONSVILLE, MD METRO CREMATORY 21. Signature of Juneral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Inter the Jisease, or complications that caused the death Joo not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final se or condition ing in death) CUD **Physician** Years /Medical Due to (or as a consequence of): Examiner 2/20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be exect Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🖪 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 TYes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baynew

Registrar

State

			For Stata Registrar	State of Marylar		artment of tificate of			ienę	007	01999
	Physici		1. Decedent's Name (First, Middle, Las William	Α	Cu	ıttler		2. Date of Dear Month Januar	- Day	3 2007	3. Time of Death 6:10P M
3.3	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Deat		ĭ	County of Death	0.101
			8113 Ventnor R	oad		Pasa	dena		1	Anne Arundel	
	Funeral Director		5. Social Security Number 202-26-6146 6. Sr  Usual Residence of Decedent	7. Age (In yrs. 72) 72 72	last birthday) Yrs.	If Under 1 Year Months Days		(Month, Day	Year) 1934	Cour	place (State or Foreign ntry)
	yland sow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	Od. Inside City Limits
	e Mar	ctor	MD Anne A	rundel Pa	sadena						1 ☐ Yes 2 🛣 No
	th with th	ai Director	10e. Street and Number 8113 Ventnor Roa	d		10f. Zip Code	21122	1	0g. Citiz	en of What Cour	USA
980	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mentalle Hydiene. Depertment of Heelih and Mentalle Hydiene. Depertment of Histem 27 is marked other than "natural", or itema 23a or 28a-f show minjordent: if item 27 is marked other than "natural", or itema 23a or 28a-f show eny injury or other traumatic avent, the Medical Exertical must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Narried 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cul I ☐ Yes 2 🛣 No	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		4. Race - Americ Black, White, Specify: Wh	
2 2	72 ho natur	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	lent's Usual Occu	during most of wo	rkina	16b. Kin	d of Business/In	dustry
Baltimore, Maryland 21215-0036	ed within ygjene. nar than " it, the Mailt,	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) +4	`life. L	Engine	er			ectronic	:/ Steel
yland	buld be fii Mental H arked otl atic aver	To Be	17. Father's Name <i>(First, Middle, Last)</i> Frank	Cuttler			18. Mother's Nar	ne (First, Middle, I ence	Maiden S	Gumame)	Lewis
Mar	12 sh h and h and 7 is m traum		19a. Informant's Name/Relationship (1		19b. Mailin	- M	t and Number or Ru				
<u>ნ</u>	Heelt Heelt tem 2 other		Marieta Cuttle  20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of	entnor Ro	ad Pasade	na N	1D 21122 ation - City or To	own, State
E O	Pages nent of nt: If i		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval from State	-	natory`or other plant ematory	Inc. 1/25			imore,M	
Balti	permit. Departn Imports eny inju		21. Signature of Fv eral Serv's Li	1//	22	. Name and Addr		allings F	uner	al Home	
			23a. Part1. Enter the dis a se, or comp shock, or heart failure. List only	elications that days id he dear						, 21122	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Metastatic		n tumo	- 1		$\cap$ $\circ$	1024	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	juence of):		4		-	1	
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687	ificate g phys	edicai		d							
P.O. Box	The law requires that the death certific site hes been signed by the ettending p pege 2 should be detached for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn: 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	ıl death 3 ☐	Ectopic pregnand Other (specify)	су		23	3d. Date of delive Month	ery Day Year
٦.	s thet the ned by edetac	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause g	ven in Part I.	23e. Did tol	acco us	e contribute to th	ne cause of death?
ords	w require been sig should b	ted b						1 □ Ye	s 2 🗆	No 3□Prob	ably 4 Munknown
l Reco	The law r cete hes be pege 2 sh	Completed	7					24a. Was a autops perform	med?	prior to coi death?	psy findings available mpletion of cause of 2 No
Zi tz	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only on			
Division of Vital Records,	To the Hospitel or Attending Physicien: The is within 24 hours efter death. To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page	ıtlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 🗆 Nursing r	10me 5 Reside 28d. Describe ho			<u>()                                    </u>
Divis	ei or Atter s efter dea ii Diractor id in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		eet, factory, office		28f. Location (St City or Town	reet and n, State)	Number or Rura	l Route Number,
	To the Hospitei within 24 hours e To the Funeral I completely filled	edicai (	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the vestigation, in my	ime, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) a ate and p	and manner as si place, and due to	ated. the cause(s)
	To the within To the Comp	×	29b. Signature and title of certifier	5		29c. Licer	se number	2	9d. Date	signed (Month,	Day, Year)
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	1,7			RI, 8109 R	tchie	Print) High u	vay, Pa	rsadeer	ia	MDal	122
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 6	32. Penistrar's Signa	ature-	200					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month John Jack Charles 10:06 AN Cole /Medical JANGARY 24 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAltimore Washington Medical Glew Burnie Centil ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 24 1955 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days 1 X M 2 □ F 218-64-5110 Director 51 July Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show must be notifled 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7769 01d House Road items 23a 21122 Funeral and 2 should be filed within 72 hours after death eaith and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status than "natural", or iten he Medical Examiner Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail Art Supply Store Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be S. John Cole Alma Gerber ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 Department of Health a Important: If item 27 Is Phyllis A. Cole (spouse) 7769 Old House Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc injury Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 M</u>ountain Road, Pasadena, MD 2<u>112</u>2 23a. Part1. Enter the neease, or complic it ns that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only on cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or e Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending properties as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 4 ☐ Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 2 ER/Outpatient Medical Certification: To 1 Inpatient 3□ DOA 27. Manner of Death 1 Anatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

2 6

Hospital 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)